Psychological Therapies in the NHS
Science, Practice and Policy
Conference 30th November 2007

INFORMAL NOTES

Jeremy Clarke

Lord Layard as our Santa Claus!
Psychological therapies are on Gordon Brown's mind due to Richard Layard and David Clark has spent more time than anyone else on the panel on this issue. I think there are 3 extraordinary things which have happened, Cabinet bringing us together as therapies in a general; in a spirit of comradeship; not just for 3 years but so that this can continue; **huge job to persuade PCT's and GP's**

Basic points which enabled the money to be granted; and to overcome the stigma

1. mental illness is the single biggest cause of misery (bigger than poverty) and the fact that to be deprived of a healthy state of mind is enormous deprivation
2. depression – according to recent BMJ article, only one in four in treatment; why only 1 in 4? Because we are not implementing NICE Guidelines which state 'Mild' or 'Recent' – we are not implementing due to lack of provision/money
3. Costs money; in comparison to physical pain such as arthritis where people do receive treatment according to guidelines.

NICE Guidelines are up for debate; 'evidence' is how we have got the money, and how it will continue and how we can convince PCT's and GP's.

Professor Tony Roth

Science defined by plurality of methods; strives towards development of ideas, it is defined by its openness to ideas and prides itself on 'getting it wrong'. I don't want to say that all comes from RCT's but it is a critical way to show what works. For example, PTSD; RCT's showed counselling can actually make things worse. What is needed is

1. more research from different therapies; there is an imbalance towards CBT at but no reason why it should be so
2. more research into process; how can we prevent harm? practice based resources and how to feed that back?
3. Better modelling of psychological distress

- mentalization is a model which links clearly to shifting behaviours (A. Bateman)
- anxiety disorders; affect sizes have gone up due to better psychological modelling; cognitive neuroscience

"Evidence-based is not necessarily reductionist"

Linda Stephenson
November 2007

Alison Faulkner

Myself as service user
I have been turned down on the NHS; have to pay a lot of money privately for psychotherapy and with regard to hearing voices; you do not necessarily need to medicate away.
Better access to therapies; one size does not fit all and partnership with service users is very important therefore, we need to develop plurality of methods – what other methods than RCT's can be develop to provide evidence:
Sexual abuse amongst women using mental health services; what can we do to stop this?

Professor Peter Hobson
Tavistock

We are talking about 'our' mental health; social realities

1. varieties and complexity of individual psychological distress; a non-bullying approach
2. helping people not contracts (?)
3. relation
4. power of inter-personal

A 'one size fits all' approach will fail!!
Transformation of power is needed; regarding depression, how apt is the medical model?
The 'We need to Talk' documentation is a an excellent document.
It is important to study how 2 people together can deal with emotional difficulties? in a dyadic relationship – its not nit-picking but critical, efficiency and effectiveness matters.

Re outcomes; mental illness does not always result in positive outcome (need RCT study over 3 years)

This CBT approach does not just need to get people back to where they were but also to allow something 'new' to develop.

Professor Suzie Orbach

Ethical dimension; mental distress is number one form of distress and my stance is based on patient's needs – how can we do this with the services we have?

- may need short-term initially (and go on to something else later)
- also some who may find short-term damages them; they need continuity

Need a relationship which will be there whilst they change.
I work from a psychoanalytic perspective – the government has understood
From a woman's perspective, we need to understand why a woman stays in an abusive relationship? Need to understand and help her psychological behaviour
PP has a way of understanding what she is doing; interesting and useful research wise; studies people in the process of change; to teach them how 'to be on their own side'
From a psychological perspective; to provide a relationship that can give the possiblity of a secure base; to give dignity. As a psychotherapist, I have the privilege of hearing and seeing how a kid can go on to have a different relationship with his body; my work is patient and therapist led.
"What kinds of evidence do we need to develop?"

David Veale

Not just RCT's

- experimental designs
- case studies with multiple baselines
- mediational studies
- audits of routine outcome
-

Follow the data to inform patient choice

Professor Louis Appleby

Optimistic time for those of us advocating psychological therapies; it is taking off.

Expecting a new model of delivery – how? It is quite daunting

At the heart of change has been 'crisis resolution' ; used argument of what patient wanted alongside evidence-based. Returning people to a place in mainstream society.

Policy
Patient
Clinical model

It is the job of NICE to prepare clincial guidelines. There is now 'much greater availability'. Stepped Care was quite radical difference from primary to secondard care; move through system according to need. NOT exclusive of any type of therapy but crucial phrase is 'evidence-based' Need to have evidence as £170m does not come as a cheque where people can write any therapy they like on it. There is an opportunity to develop evidence other than CBT.
Remember to integrate short therapy with social care; it will play out differently than purity of NICE Guidelines
Lessons

- radical clinical model
- harnessing clinical experience
- early adoption

"90% of mental health is currently contained within GP practices; more training in GP surgeries is needed" Andrew, APP
"Tragic loss of the Henderson and the Cassell".

Not intention to exclude therapies which have not gone through RCT; patient preference is a kind of evidence; the choice the patient makes will have a significant effect.

Life is more complex than to be centred around one or two therapies but what we do have is an unstoppable government policy whereby they have put money towards psychological therapies; be careful not to dampen this down by arguing amongst ourselves; real people are in these trials; need to turn the good evidence into something that works in practice.

David Creapaz-Keay
MIND

I was made to feel worse therefore I lied, said I was better – bingo!, evidence that the result is it works! Vast majority of people want talking treatments but not for good reasons;

- had it and its helped *(this is only good reason on list)*
- people are desperate and talking therapy might help
- anything which is not a drug may be better

Caution for those who want talking therapy;

- talking therapies are no more guaranteed than Prozac
- be careful about putting people into diagnostic boxes (I had 6!)
- we do not want to be passive receivers
- psychological treatment does not have a good record of talking service user viewpoints
- talking therapies there for people believe

Crticism of therapists is that they can be 'smug, patronising, creating dependency on you – be careful not to become this!

Since this government initiative, we have been able to talk about poverty and social exclusion and we need to be cautious about it being used subsidize the middle classes who could pay for this anyway. We need individuals to define own desired outcome.

I wanted to become an economist which some would say was an early indicator of psychosis! most tried to stop the voices, none tried to help me become an economist.

Self management; don't define by social class, gender, etc but define by where they want to go. We do not want a diagnosis which maps out someone's life by a diagnosis at the age of 13.

Professor Glenys Parry
IAPT Diretor

Based on cohort of 1400 people, so far we have established that demonstration sites do improve access to utilization and outcomes of psychological therapies. We have a 3 year timescale wherein policy research has three strands; costs and outcomes, system impacts, patient experience.
Miriami & Wampold, 2007 – Benchmarks in Clincial Outcomes/Depression
Qualitative; patient journey and experience ("How can we fail when we are so sincere?" Snoopy) Need to be open to scrutiny and skepticism.

Dr Ian MacPherson
Dept of Health
National Director NIMHE
Care Services Improvement Partnership

We use the 'methodological' defence "that doesn't fit with my personal view of the world" is a view that exists but remember that 900,000 extra people will get talking therapies. £173 million will transfer to people in PCT services; will get individual budgets. Cannot currently buy psychological therapies but maybe this is a way to go; health vs social are budgets are separate.

Difficult to differentiate however if it is possible identify when someone is experiencing anxiety or depression in addition to relationship difficulties (like the rest of us) – it is a 'both/and' situation

PM
Professor Elliott

Summary of evidence for person-centre

Frank Margisson
Psychodynamic Perspective

Difficulty with psychodynamic psychotherapies is that we don't even know what *'psychodynamic'* is; we don't really even know if the way psychodynamic therapist practice is the same therefore, before we start, we have an issue with definitiion.

Svartberg & Stiles (1991)
Crits-Cristoph (1992)
Anderson & Lambert (1995)
Leichsenring et al (2004)
** Abbas et al (Cochrane Review) 2006 LS READ THESE

Despite the above being good meta-analysis, there is no overlap and major definition problems. However, there are common positive outcomes

- active therapist
- positive alliance
- takes action to repair alliance breaches
- transference in 'here and now'
- setting achievable goals

Affect

- affect and interpersonal
- patterns of relationship

Cochrane Review

- STPP appears effection

What it is not? As distinct from CBT

Professor J Markowitz
New York

IPT does not interpret the transference

- is included in APA Guidelines for depressive disorders, bulimia

Choosing appropriate therapy for particular disorder is crucial – 8 - 12 sessions; maintenance, closing plus telephone IPT

Why choose IPT? Why not choose IPT?

- patients with no life events should not get IPT (CBT instead) because it is interpersonal based.

Professor Lars Goran Ost
Stockholm University

CBT is recommended for specific phobias, social phobias, panic disorder with agoraphobia.
Why is psychodynamic psychotherapy missing from being recommended?
FM "weakness of trying to define"
"In NY City; other therapies ignored the DSM critique unlike CBT/IPT which is why they have flourished"
Ost "not enough focus on specific disorder for psychoanalytic therapies"
NY "It would be wonderful if you could train therapists to do 2 methods competently but event to get people to train really well in one would be great; with referral system.

Professor Jacques Barber
USA

Outcomes in psychodynamic psychotherapy
In USA, we have the pressure of comparing our treatments to medication which doesn't seem as much of an issue here. It is very impressive to see the UK government funding psychological therapies; our country is funding other things!

Superior to pill - in manual (?)

There are few studies comparing STDP to other therapies – why not?

Dr Barbara Milrod
New York

12 weeks is standard med trial therefore that is how we matched it. Short-term therapy really telescopes the transference. Calm and assured manner of the therapist calms the patient (Greenacre) Exposure not done as it alters the transference.

JB: Why not efficacy studies?
- lack of traditon
- case studies
- lack of emphasis on diagnosis

<u>Problem/shortcoming of RCT's</u>

The therapist is always variable therefore never equal
- based on experimental approach ie only difference is between groups
- participants are representative
- patients showing diagnosis are similar but respond differently

Can we do enough RCT's in the time we have left?

Create a more pluralistic approach

David Clark " told patients a lie; mediation; is it just changing attributional style ie telling a different story? The other thing is that patients are getting better before we do anything sometimes…what is this?"

Nick Temple "RCT's are difficult, rare and expensive – what can we do?"

Jacques Barber "Not supportive of a difference – quite amazing"
"Try to link with neuro-imaging"
CORE is important for research-practitioner
Jacque Barber "Michael Lombard – great study
Rememer how medical industry suppressed all their negative studies.
Steve Cooling "NICE Guidelines; Lambert studies very impressive on therapist's competencies.
David Clark "Research needs to show how therapy is doing more than a caring person ie someone being nice and supportive"

SATURDAY 1st DECEMBER

Paul Farmer
Chief Executive Mind

Citizens; not users
Stronger user voice; less drugs; more talking therapies
Darzi (?) Review

Lord Richard Layard

Mind has played enormous role in part of getting to where we are now. So how will it play out:

Team of 40 therapists for London; 7,500 – 8,000 for England
Delivering therapy via stepped care
Step 3 care therapists 60% high intensity
Step 2 care therapists 40% low intensity

Team would need experts supervising etc in centre; or in GP's surgeries; also be self-referral based on pilot sites – not worried well but those who are very unwell. Centres run by therapists, as defined by NICE. All outcomes would be monitored.

Shortage of people trained in CBT – will have to be major training in CBT; 2 days a week training, 2 days practice; 1 day supervision lasting 1 year in University. Could not be done in less than 6 years but we must do that.

Money in 1st year in each of 10 regions;
1 training centre for high intensity
1 training centre for low intensity i
This will be set up in the coming months; 500 trainess in year 1; 1000 in year 2

This has the support head of the Head of the NHS, David Nicholson therefore it is embedded within NHS. Pressure on every PCT to 'up' its access to psychological therapies out of its own budget; probably more important what the GP's and users say – so we need them to demand; need continuous and relentless pressure to change/implement

Professor Andrew Cooper
NHS Tavistock Trust

A social mode of mental health; seminal paper by Tyrill Harris "Social Origins of Mental Health" re depression.

I think problems are too complex to be researched using RCT's
R. Wilkinson, University of Nottingham – excellent research
Is a linear process in complex social processes a suitable model?

Gillian Finch
CIS'ters

Lack of continuity in the home crisis team; problem with diagnosis in NHS has been that people are not treated as individuals; now has to pay for therapy. NHS was dire for me; not treated as person; group therapy; people treated as their disorder rather than as a person; or

look at the cause; labelling does do something to the patient; some people who go for help are told they are too well…or too ill!
If I had had to wait for 8 months for therapy, my motivations would have changed; there should be a multi-disciplined team available at these centres and use the voluntary sector. (what is the role of voluntary sector going to be in all of this?)

Sir Michael Rawlins
NICE Chairman

A 'star list' organisation; 5 different programmes related towards health; all can have their say but not necessarily their way!
1. Effective; not talking about method but I am talking about 'fit for purpose' for answering particular question
2. Cost efffective; you are out of your mind if you don't respect this; spending is roughly equivalent to GDP – it has to be fair to everyone

There is a lot of criticism for lack of psychological therapies available; I have a "Hated by the Daily Mail" t-shirt which I'm proud of actually.

NICE Guidelines on schizophrenia regarded as the best in the world (from Germany)

Angela Greatley
Sainsbury Centres

Interested in the 'how': the processes

NICE Guidelines will shape the 'how' and what goes into the future

Influence that practice-based practitioners will have….

Take poverty, inclusion/exclusion very seriously – good that we are talking about psychological therapies. Need to define:

What is it that we do do?
What do people want?

Could be possible that direct payments are made to people for psychological therapies?
Be very wary of over-promising. 'Therapeutic relationship doesn't feature much in the research evidence?
Linear and non-linear thinking
Want psychotherapists to be involved in this process

Lord Richard Layard

Prevention more important than cure; spent most of my life fighting for equality surely its 'both/and'

Andrew Cooper

Concern that paradigm of NICE Guidelines are not fit for purpose

Where are we now? No treatment is effective for everyone therefore we need to identify existing treatments which means effective therapies. How? By routine monitoring for all our clients.
Eye of IAPT will generate richer tapestry of outcome results for therapies.

Research
Identify core cognitive abnormality (listen to client, clincial observation and cognitive psychological experiments)
Develop theory of why abnormality exists (LS go to website for presentation)

CBT has shown to be particularly effective for social phobia (and PTSD) for example, may have been bullied at school. Why?

- attention shifts to internal
- -aware of internal information which they infer how they are to others (often video picture of themselves - they see fears visualized)
- safety behaviours; these won't change because by doing this they survived but it means they appear less interested in others and it creates the very thing they are afraid of
- become aware of particular visual images (80% negative visual internal images)
- this mental image leaks…picked up by other people

CBT is about helping people to get out of their heads and lost in the outside world

- use of video to show
- rescript early social traumatic memories and to discriminate between the then and the now

PTSD
Persistent and people see as a current threat

- excessively negative appraisals
- unusual autobiographical memories; no time code

Some people:

- treat trauma as normal event and it will go away with time

Others:

- there is something wrong with me

Disjointed initial recall is good predicter
Goal 1: is re-experiencing; imaginal re-living, narrative writing and putting time code into memory
Goal 2: modify excessive negative appraisals; spot individual 'hot spots', explore meanings and insert new meanings

Thought suppression makes memories appear more. Unambiguous evidence shows some counselling can do harm (Mayal, Hobbs & Ehlers, 2000).
Debriefing retards recovery.

** Not just empathic therapist, there is something more

1 week intensive treatment?

LS; noticed that this presentation was peppered with the word 'nice' ! *'there is some rather nice work being done here'* I wonder how conscious this is?

Proven efficacy of range of therapists
Greatest organisation asset that NHS has
Is an issue about researcher allegiance that we need to address; Irene Elkins is an icon as a psychotherapy researcher

Stiles et al (2007) 'Psychology & Medicine", Commentary, David Clark

Can we find a more common language? Regardless of therapy; Irene Elkins, Psychotherapy Research (2006) showed *no therapist effect,* Wampold et al (200?) showed *significant therapist effect* so it depends on who you ask!

RCT's aim to reduce therapist variability – threat to internal validity: therapist often treated as 'fixed' rather than 'random'. Therapist as design variable so how do trials assess therapist variables; therapist effect is always going to play out in the analysis.

Elkin's (1999) advice is to include supervisors and peer group (Stiles shows 70% therapist variable, Lutz show 17% therapist variable)

Okiisi et al (2003) 'Supershrink', despite not liking this word, it is used to describe how some therapists are 10 times more effective than average therapist. Why?
There is a range of 9% - 94% with an average of 59% effectiveness for therapists; case mix adjustment.

Success Factors

- client in full-time employment
- quality of practitioner-client alliance
- (Baldwin, 2007) therapis offered alliance

** 'The Farmer' is often not looked at as a variable

Research Directions
Who is working best with people and what are they doing? and try to encompass practitioners in this.

CORE
Individuals vs National which means practice-based data (CORE-NET)

Case Study

- is 10

What is an effective psychological practitioner? Need to build a theory of an effective practitioner.

Conclusion
** Need for as much focus on practitioners as there is on treatments
** Issue of researcher allegiance
** Database from routine practice

Policy
Funding for practice-based research (and evidence) – 5% of all this money should be provided for some research students to concentrate solely on this type of research.

Q&A
The 'mind' behind the analyst; does the 'mind' behind the practitioner enable?
Routine Outcome monitored via CORE and IAPT; CORE was introduced 10 years ago to introduce some standardization, which was a mess at the time, and to provide information for practices.

Interesing where one is not effective – should be major focus also.

Professor Catherine Itzin
NIMHE & DoH
National Institute for Mental Health in England

Domestic Violence and Abuse
Stepped care is the perfect approach for these groups; maps perfectly onto NICE Guidelines for stepped care. CORE immersed in medical model, would be useful to have some stories of how people have come through this "I am a survivor and these things have saved my life". Certain kinds of abuse can only come from telling certain stories and of other's experiences. Some things just don't seem to fit.
Re Victimisation; there has been a lot of perversity in government policy
Need a systematic approach which recognises differing needs
Victims/Survivors want to be 'inside society' and part of things – not outside the system

"Nothing bad happened to me" – but an assessment can clearly identify someone with needs.

See it as operating flexibly and not mechanically; stepped care is inclusive not exclusive. An individual will tell you what they need, even if they don't understand, if you ask them.
At the Cassell, therapists, patients, professionals and family all get together to discuss the transference – very powerful meeting, how can we integrate this type of thing?

Ian MacPherson; Splitting will only not occur if we stop it/prevent it happening

Professor Peter Fonagy

What have we learnt and what do we still not know? I really don't know! but I've never seen so much anxiety about receiving £170 million – and we all know that we cannot think when anxious!

Frame that has been created is very worthwhile; moved away from government driving it (do this, do that) to an approach which uses professionals (why do this or that?)

Evidence base does not mean best practice; we need to think in terms of heart/brain ratio – we need the heart of Mother Theresa and the brain of Einstein.

Italy doesn't have the benefit of NICE! Italy prescribes X drug (Citralen?) which is clearly ineffective. There is a well demonstrated cause and effect relationship in medicine and this is what separates it from religion! ….but this must not lead us to creating evidence-based religion.

David Clark showed us that CBT didn't have the devil's horns attached and showed an almost playful demonstration of evidence

Must be inter-disciplinary…. but what do people do in that therapy room; I've heard people say "You know what Fonagy does, its not psychoanalysis!" I would sue them if I caught them though!

Research
If you try to generalise psychoanalytic therapy, you end up with it not looking like what it is. Maybe the research will show it is a waste of time? I don't think I would like that!

Learning and trying new things in a playful way; Science is often humbling

Guilty Feelings
Defensive around modalities
Therapist competence
"Depression is cured by Brussel Sprout Therapy (BST)" - you notice there always have to be 3 letters!

IAPT Anxiety
New model for delivering psychotherapy
New models of training

NICE Anxiety
Not impossible to interpret the evidence; as David Clark showed
Is NICE fit for purpose – I would say it is better than alternatives
CBT Anxiety
** Why shouldn't dynamic treatments borrow from CBT?
What?
Time Limited
Clarity of Evidence

Worried about the disappearance of a tradition
Life elaborating and meaning oriented treatment approaches

Instil Hope
Like any good therapist, I should instil hope – I don't know if I can do that but….

Gaps in Research
No good evidence from who will benefit from what type of psychotherapy
Inexact therapies - -partial effectiveness
Attachment to methods

Need new intellectual framework
Development of psychological and neural mechanisms underlying disturbance

Science is good for practice
Practice is excellent for science

Q&A
5% of trainees used to develop the profession – bringing to psychological therapy what is learned from other disciplines

Next year's date: 21st and 22nd November 2008 (this has since changed to avoid Friday and Saturday tbc)

Linda Stephenson
November 2007