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Dear

My name is Dr Stephen Buller. I am writing with regards to apparent intentions by Derbyshire Clinical Commissioning Groups (CCGs) and Derbyshire Healthcare Foundation Trust (DHCFT) to reorganise and cut psychotherapy and psychological therapy services in Derby City and Derbyshire delivered by the Trust at secondary and tertiary care level, steps/tiers 4 and 5 in a stepped care model, for severe and complex disorders.

To place this letter in context I will say a little about myself and my work. I joined the NHS in the mid 1970's pursuing a career as a clinician and researcher in psychiatry. It was a period when psychotherapy and psychological therapy services, which had been relatively small, unsophisticated and centred in London, were starting to develop and emerge in a more devolved way in county centres. Over the next ten or fifteen years I trained in a range of psychological therapies, began working as a mental health specialist in psychotherapy, and eventually became lead clinical specialist and service manager for psychotherapy services in Derby City and Derbyshire. In this capacity I worked beyond my retirement age and left full-time NHS practice a few years ago. Moving from the NHS I now work as a clinician, researcher, academic, and in delivering strategic and organisational consultancy, across a range of statutory, non-statutory, charitable, professional, provider, and commissioning organisations.

Developing and emerging devolved NHS psychotherapy and psychological therapy services in the latter part of the twentieth century, and the therapies they delivered, can be considered as highly experimental. Nobody really knew what worked or why. However therapists were committed, and research in psychotherapy was progressing, revealing details of the therapies and to some degree their relative effectiveness. After the turn of the millennium, fifteen or twenty years ago, there was growing confidence that it might be possible to identify some therapies that would be routinely more effective for some conditions or disorders. In particular, given the evolving research evidence, it was considered that cognitive therapy might be the first-line treatment of choice for mild to moderate depression, steps/tiers 2 and 3 in a stepped care model, at primary care level. A consensus in this position eventually became a foundation on which IAPT (Improving Access to Psychological Therapies) services were developed.

There are a few things to note in the IAPT psychotherapy and psychological therapies development. Research in cognitive therapy has been rigorous with replicated studies, and has shown that the typical effectiveness of the treatment was to help about 50% of those receiving treatment to reach recovery. Recovery means no longer needing help or assistance, and functioning in a normal spectrum without symptoms of disorder or dysfunction. In the parlance of research and treatment

planning we look at the ‘number needed to treat’ (NNT), which in this case is the number of people seen for therapy before ‘one’ recovers. So for cognitive therapy, in research conditions, NNT=2 (two people treated, one [50%] recovered). This is important because it reflects achieved recovery rates in the use of approved antidepressants (50% and NNT=2), which is the gold standard for research in these forms of psychotropic medication. In other words cognitive therapy can be considered to have equivalent or comparable outcomes to antidepressant medication in the treatment of mild to moderate depression.

Additionally cognitive therapy, along with a small number of other treatments from within the cognitive-behavioural cluster, has been shown in research studies to have a significant impact in the treatment of mild to moderate anxiety disorders. Cognitive therapy has become an important and central treatment in the IAPT development. However it is important to recognise the corollary, that 50% of those treated will remain dysfunctional and symptomatic, and continue to need help or assistance. What happens to this latter group of people? IAPT services have adopted a range of other options of psychological therapies, including Interpersonal Therapy (IPT), Dynamic Interpersonal Therapy (DIT), and Short-Term Psychodynamic Psychotherapy (STPP), which all have less than optimal but important evidence for effectiveness with mild to moderate disorders. Additionally some patients, quite a few, are ‘stepped-up’ to secondary and tertiary services. From this we see that a range of available psychotherapy and psychological therapies is an important factor in developing and providing comprehensive services.

A further consideration in relation to the IAPT development has been an implementation of a national standard for local evaluation and contract management. This has meant that each IAPT provider has been required to implement routine outcome measures for every patient receiving treatment. There is now a national data set for IAPT services for the last six years. We know that early stage implementation saw a mean recovery rate across services of around 34%, however most recent outcome reports suggest that the current mean recovery rate has achieved 50%. For those running these services this is a milestone in matching service competence with what has been achieved in research studies, and with what was expected from IAPT at its inception. There are some reasons to be cautious about these reported levels of recovery, but overall this must be seen as significant in determining the effectiveness psychotherapy and psychological therapy provision, and in the ability of commissioners to monitor this progress and their provider contracts.

When we turn from psychotherapy and psychological therapy services for mild to moderate disorders at primary care level to psychotherapy and psychological therapy services for severe and complex disorders at secondary and tertiary care level there is a significantly different picture. At this level of severity and complexity we find no treatments to match the level of effectiveness of cognitive therapy in the treatment of mild to moderate depression. Dialectical behaviour therapy (DBT), part of the cognitive-behavioural cluster, has been shown in research studies to have some effectiveness in the treatment of very severe self-harm amongst a specific sub-population of personality disorder. Similarly transference focused psychotherapy (TFP), part of the psychodynamic cluster, has been shown in research studies to have some effectiveness in the treatment of another specific sub-population of

personality disorder. Other treatments such as mindfulness-based cognitive therapy (MBCT) and short-term psychodynamic psychotherapy (STPP) also appear to be aggregating research evidence for their effectiveness with these severe and complex disorders. Long-term psychodynamic psychotherapy (LTPP) also appears to have a small research foundation demonstrating some effectiveness in particular conditions.

Research studies appear to demonstrate these important forms of psychotherapy and psychological therapies can achieve between 15% (NNT=7) and 35% (NNT=3) recovery in particular conditions. When we consider research in other forms of mental health treatment with severe and complex disorders, such as pharmacological research into psychotropic medications, then we find similar levels of possible effectiveness - recovery between 15% (NNT=7) and 30% (NNT=4). In our current state of knowledge and experience we do not have an abundance of outstandingly effective treatments for severe and complex mental health disorders. Additionally, unlike IAPT for mild to moderate disorders, we do not have an implementation of a national standard for local evaluation and contract management through routine outcome measures. However some CCGs at local level ask for routine outcome measurement as part of the contracting with providers, and many NHS secondary and tertiary mental health providers collect and utilise routine outcome measures. It is possible for these commissioners and providers to monitor outcomes, evaluate and compare local effectiveness within the treatments they provide, and to work with each other to optimise service provision. We understand that in these situations outcomes do not vary greatly from those that might be anticipated from research - recovery between 15% (NNT=7) and 35% (NNT=3). It appears that outcome evaluation enables commissioners and providers to establish a rational and well considered range of psychotherapy and psychological therapies, just as has happened amongst IAPT providers, in order to maximise effectiveness for this severe and complex population.

Unfortunately it appears that neither DHCFT, nor Derbyshire CCGs, has implemented a workable approach to collecting and collating routine outcome measures in a useable form. Derbyshire CCGs and its predecessors have undertaken at least nine formal reviews of psychotherapy and psychological therapy services delivered by DHCFT, and its predecessors, since the turn of the millennium, over a period of eighteen years. That is one review very two years. At least five of these reviews proposed an implementation of routine outcome measures. If such an implementation had occurred, and proper and comprehensive outcome data was now available, it would perhaps be possible to proceed towards an informed and nuanced approach to the range of psychotherapy and psychological therapies required, just as it has been in IAPT services. However this is apparently not the case.

A further contextual perspective on this matter is possible if we consider healthcare outcomes in general – physical health and mental health. We are possibly better informed about health outcomes at the present moment than ever before in our experience of organised healthcare. However what is probably not commonly understood is how much of healthcare activity is directed towards diseases, conditions and disorders which do not recover. The treatment of diabetes mellitus has a 0% recovery rate (NNT=infinity). A similar story emerges if we examine treatments for rheumatoid arthritis, coronary heart/artery disease, obstructive

pulmonary disease, and neuro-muscular diseases. All or most cases within these major categories have little hope of recovery (0% and NNT=infinity).

There is perhaps a stark and informative comparison with cancer treatments. There is general agreement that survival rates for those with cancer are probably improving according to data sources over the last two decades. However this is 'survival' not 'recovery' as is defined in healthcare outcome analysis. Additionally there is also caution about the possible influence of changes and innovation in cancer treatment on improved survival rates, and a recognition that the quality of cancer services is dependent on a range of treatments even though the effectiveness of an single treatment might be relatively low. Calculations of effectiveness in cancer treatment, taking 10 year survival as the benchmark achievement, range approximately from 0.1% to 5% with a mean at 1% (NNT=100). These effect sizes for cancer treatment are much lower than those achieved by psychotherapy and psychological therapies with severe and complex mental health disorders.

In Derby City and Derbyshire new cases each year needing cancer treatment, and those needing secondary/tertiary psychotherapy and psychological therapies are approximately equal (≈5,000 new cases). However the cost per case for cancer treatment is perhaps as much as 4.5 times larger than for psychotherapy and psychological therapies at secondary/tertiary level, and psychotherapy and psychological therapy services receive perhaps as little as 3% of the amount of funding received by cancer treatment services. This difference in funding means that although all new cases of cancer can access treatment only 10%-15% of new cases with mental health disorder can access treatment. It is perhaps no surprise that referrers, and patients with severe and complex mental health problems, find such great difficulty in accessing these specialist psychotherapy and psychological therapy services.

The term 'Parity of esteem' can be defined as valuing mental health equally with physical health. It assumes equal access to the most effective services and treatments, and equal status in the measurement of health outcomes, for people experiencing mental health difficulties. The term itself had been evoked in the Health and Social Care Act 2012 and is given prominence in the NHS 'Five Year Forward View for Mental Health' published in 2016. These place legal and strategic duties on CCGs and Health and Wellbeing Boards to ensure parity of esteem is being met.

In summary and conclusion:

- It appears there are intentions by Derbyshire Clinical Commissioning Groups (CCGs) and Derbyshire Healthcare Foundation Trust (DHCFT) to reorganise and cut psychotherapy and psychological therapy services in Derby City and Derbyshire delivered by the Trust at secondary and tertiary care level for severe and complex disorders.
- IAPT developments of psychotherapy and psychological therapies services for mild to moderate disorders at primary care level have made use of research which showed that cognitive therapy has typical effectiveness in the treatment of depression of about 50% of those receiving treatment to reaching recovery (NNT=2). It is important to recognise the corollary, that 50% of those treated will remain dysfunctional and symptomatic, and continue to need help or assistance. For this latter group of patients IAPT services have adopted a

range of other options of psychological therapies which all have less than optimal but important evidence for effectiveness with mild to moderate disorders. A range of psychotherapy and psychological therapies is an important factor in developing and providing comprehensive services.

- In secondary and tertiary care level psychotherapy and psychological therapy services for severe and complex disorders we find no treatments to match the level of effectiveness of cognitive therapy for mild to moderate disorders in IAPT. However there are a small number of treatments that appear to have some research justified application, including psychodynamic psychotherapy. In research studies we find these important forms of psychotherapy and psychological therapies can achieve between 15% (NNT=7) and 35% (NNT=3) recovery in particular conditions for severe and complex disorders.
- These levels of effectiveness are similar to the effectiveness of other forms of mental health treatment with severe and complex disorders. In pharmacological research into psychotropic medications we find levels of effectiveness in the range 15% (NNT=7) to 30% (NNT=4). In our current state of knowledge and experience we do not have an abundance of outstandingly effective treatments for severe and complex mental health disorders.
- In the IAPT development a national standard for local evaluation and contract management through outcome measures was implemented. Has been as a significant in determining the effectiveness of provision, and in the ability of commissioners to monitor this progress and their provider contracts.
- Unlike the situation in IAPT we do not have an implementation of a national standard for local evaluation and contract management of secondary and tertiary services through routine outcome measures. However some CCGs at local level have implemented routine outcome measurement as part of the contracting with providers, and many NHS secondary and tertiary mental health providers collect and utilise these measures. It is possible for these commissioners and providers to monitor outcomes, evaluate and compare local effectiveness within the treatments they provide, and to work with each other to optimise service provision. We understand that in these situations outcomes do not vary greatly from those that might be anticipated from research - recovery between 15% (NNT=7) and 35% (NNT=3). It appears that outcome evaluation enables providers to establish a rational and well considered range of psychotherapy and psychological therapies, just as has happened amongst IAPT providers, in order to maximise effectiveness for this severe and complex population.
- Unfortunately it appears that neither DHCFT, nor Derbyshire CCGs, has implemented a workable approach to collecting and collating routine outcome measures in a useable form. If this implementation had occurred, and proper and comprehensive outcome data was now available, it would perhaps be possible to proceed towards an informed and nuanced approach to the range of psychotherapy and psychological therapies required, just as it has been in IAPT services. However this is apparently not the case.
- When we compare outcomes and spending between physical health and mental health there is a stark difference. Outcomes for psychotherapy and psychological therapies for people with severe and complex disorders are often better than those receiving treatment for physical health condition. In the case of cancer treatment outcomes are far worse than those achieved by psychotherapy and psychological therapies. However in Derbyshire funding for

cancer treatment is perhaps more than 30 times greater than psychotherapy and psychological therapies for the same number of patients.

- There are legal and strategic duties placed on CCGs and Health and Wellbeing Boards to ensure ‘parity of esteem’ for mental health. However this obligation is not being met.

Thank you for taking time to read this letter. I will welcome dialogue and discussion with you about these matters.

Yours sincerely

Dr Stephen Buller