DET PSYKOLOGISKE FAKULTET

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A comparative analysis of the initiatives "Improving Access to Psychological Therapies" (IAPT) in England and "Psychologists in Primary Health Care" in Norway

HOVEDOPPGAVE

profesjonsstudiet i psykologi

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Forord

Vår interesse for psykisk helsearbeid i primærhelsetjenesten har sitt utspring i et ønske om å lære mer om hvordan psykologers kompetanse kan nå ut til flest mulig mennesker. Inspirasjonen til oppgaven fikk vi blant annet gjennom kurset "Forebyggende samfunnspsykologi", der forholdet mellom det begrensede antallet psykologer i Norge og den høye prevalensen av psykiske lidelser ble problematisert. I både England og Norge har oppbyggingen av psykiske helsetilbud innen primærhelsetjenesten vært et politisk satsingsområde det siste tiåret, og resultatet av denne satsingen er et dagsaktuelt tema både for psykologprofesjonen og sentrale myndigheter.

Denne hovedoppgaven er skrevet i henhold til regler for innsending av debattartikkel til BMC Health Services Research (se appendiks 1).

Vi vil takke vår veileder professor II Arnstein Mykletun for idé til prosjektet og for lærerik og stødig veiledning. En klargjøring av vårt selvstendige bidrag til denne artikkelen følger av vedlagt brev i appendiks 2.

Title page

Type of article: Debate

Title: A comparative analysis of the initiatives "Improving Access to Psychological Therapies" (IAPT) in England and "Psychologists in Primary Health Care" in Norway.

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Sammendrag

Bakgrunn: Det finnes en tredelt utfordring innen psykisk folkehelse: 1) majoriteten av mennesker med psykiske lidelser får ikke behandling; 2) det er ikke nok kvalifisert helsepersonell til å tilby individuell behandling til alle som lider av psykiske lidelser; og 3) ubehandlede psykiske lidelser er en økonomisk byrde for samfunnet og en alvorlig helsetrussel for de som lider av dem. Det engelske initiativet: "Improving Access to Psychological Therapies" (IAPT), og det norske programmet: "Psykologer i kommunehelsetjenesten - modellutprøving" (PPHC) er implementert som tentative løsninger på disse problemene. IAPT tilbyr behandling av angst og depresjon i primærhelsetjenesten. PPHC søker å rekruttere psykologer til norske kommuner og tilby behandling og forebygging av psykiske lidelser. Denne artikkelen er basert på en sammenlignende analyse av IAPT og PPHC.

Diskusjon: IAPT kjennetegnes av nasjonal ledelse som bidrar til å utvikle nasjonalt likeverdige tjenester. Innholdet av tjenestene bygges på en solid evidensbase. IAPT-tjenester er per dags dato tilgjengelige for omtrent 60 % av befolkningen. PPHC kjennetegnes av høy grad av lokal autonomi, uten klare retningslinjer for å sikre likeverdige tjenester i forskjellige kommuner. Det er ukjent hvor stor del av befolkningen som har tilgang til PPHC-tjenester.

Oppsummering: IAPT omfatter grundig spesifiserte, evidensbaserte tjenester som evalueres kontinuerlig. PPHC mangler disse kvalitetene, men har fordelen av å inneholde forebygging som potensielt kan være med kostnadseffektivt enn behandling. Det er uklart om den lokale autonomien i PPHC fører til klinisk eller forebyggende arbeid.

Abstract

Background: The challenge in public mental health is threefold: 1) the majority of people suffering from mental illness receive no treatment; 2) there are not enough mental health professionals to offer individual treatment to all who suffer from mental illness; and 3) untreated mental illness is an economic burden to society and a serious health threat to those suffering. The English initiative: "Improving Access to Psychological Therapies" (IAPT), and the Norwegian programme: "Psychologists in Primary Health Care" (PPHC) have been implemented as tentative solutions to these challenges. IAPT involves treatment of anxiety and depression in primary health services. PPHC aims to recruit psychologists to Norwegian municipalities and provide prevention and treatment of mental disorders. This article contains a comparative analysis of IAPT and PPHC.

Discussion: IAPT is characterized by strong national government, ensuring equal services across the nation. The content of the services is justified by a solid evidence-base. IAPT services are currently available to about 60% of the population. PPHC is characterized by a high degree of local autonomy, without clear guidelines to ensure equal services in different municipalities. The percentage of the population with access to PPHC services is unknown.

Summary: IAPT involves thoroughly specified, evidence-based services that are evaluated continuously. PPHC lacks these qualities, but has the advantage of containing prevention which can be more cost-efficient than treatment. It remains to be seen whether the local autonomy in PPHC will facilitate clinical work or prevention.

Keywords

IAPT, NHS, primary health care, mental health services, public health, psychological therapies, organization of health services, prevention.

Background

The burden to society of common mental disorders is increasingly recognized. About one third of the population meet the criteria of at least one mental disorder in any given year, a number rising to half the population during their lifetime [1-6]. This prevalence is representative for developed countries and seems to be stable over time, with some reports going back to the 1940s [6-20]. The expenditures associated with mental disorders are prominent. The World Health Organization estimates the cost of mental disorders to be between 3-4% of gross national product in developed countries [21]. In addition, there are considerable hidden costs in the form of expenditures on ineffective or inappropriate treatment, disability pensions, sickness absence and loss of productivity [21-24]. In most European countries, mental disorders account for about one-third of disability pensions, and for the last two decades this proportion has increased [23, 25, 26].

For the individuals affected, mental illness can entail impaired functioning and somatic health, loss of income and increased mortality [27-30]. Reports indicate that "…depression as a risk factor for mortality is comparable in strength to smoking" [28]. Further, unipolar depression is considered to be the number one cause of burden of disease (DALY), or years of life lost from premature death or life lived in states of poor health or disability, in middle- and high-income countries [31]. In developing countries evidence shows correlations between mental illness, poverty and increased mortality [24, 32, 33]. In addition to the negative effects of mental illness on the person suffering, the consequences also

appear across families and generations. Children suffering from mental illness affect their parents' functioning and productivity [34], and parents' mental illness influence their children's behaviour and mental health [35].

Despite of the negative implications associated with mental disorders, most people suffering from mental illness receive no treatment [36-39]. This is especially apparent in the case of common mental disorders like anxiety and depression [40]. It is a paradox that even though there exists effective treatments for mental disorders [41, 42], and there has been an increase in treatment offered during the last decade, the prevalence remains unchanged [4]. Two explanations have been offered: Either the prevalence of mental disorders would have increased had it not been for the increase in treatment, or the increase in treatment did not affect the prevalence [4]. It is argued that the latter explanation is more likely [4]. This is based on the fact that the increase in treatment has largely occurred in the sector of general medical services offering pharmacotherapy, and that 50% of patients receiving treatment did not have a disorder according to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) criteria [4]. Although pharmacotherapy is indicated in the treatment of some mental disorders, like severe depression and schizophrenia [41, 43], there is little evidence that it leads to a significant improvement of mild disorders, let alone subthreshold syndromes of mental illness [4]. It is therefore unlikely that it will affect the prevalence of such disorders [4].

Both in England and Norway, national guidelines for best clinical practice recommend a stepped model of care in the treatment of common mental disorders [36, 41, 44-46]. The stepped care model has two fundamental features. First, the recommended treatment should be the least restrictive treatment available with a reasonable chance of improvement. Second, the outcomes of treatment is monitored and treatment is adjusted

when necessary [47]. According to the guidelines on depression, people suffering from subthreshold, mild or moderate depression should receive low-intensity psychosocial interventions [36, 41]. Clients who do not show improvements from the low-intensity treatment should be offered either an antidepressant, or a high-intensity psychological intervention like cognitive-behavioural therapy (CBT) or interpersonal therapy. Severe depression should receive multidisciplinary treatment in form of medication, high-intensity psychotherapy and/or electroconvulsive therapy. In addition, the person's preferences for treatment should influence which intervention is chosen [36, 41].

It is important to emphasise that both psychological therapy and pharmacotherapy are recommended in the stepped care model, both being regarded as an important part of the health services provided. The key point is that if the first treatment modality does not benefit the client, another modality is indicated. Medication is only indicated for subthreshold, mild and moderate depression if low-intensity psychotherapy does not work or is not preferred by the client [36, 41]. Research on patient preferences indicates that the majority of people with depression prefer psychotherapy [48-50], but many receive medication [4]. This might be due to a lack of available psychological treatment in primary care [49, 50].

During the past decade there has been an increase in the use of pharmacotherapy, but no parallel increase in the availability of psychotherapy. Regarding public mental health the governments' challenge has been threefold: 1) the majority of people suffering from mental illness receive no treatment; 2) there are not enough mental health professionals to offer individual treatment to all who suffer from mental illness; and 3) untreated mental illness is an economic burden to society and a serious health threat to those suffering.

In 2005-2006 the Norwegian and British governments independently formulated two tentative solutions to this challenge involving extended services in primary health care. Both are established as a supplement to existing services in primary health care, and propose a possible solution to the challenge in mental health care. The Norwegian and British health services are of similar organization, which makes the two initiatives well suited for comparison.

This article contains a comparative analysis of the two initiatives "Improving Access to Psychological Therapies" (IAPT) in England and "Psychologists in Primary Health Care" (PPHC) in Norway. The IAPT programme aims to implement national guidelines and offer first-line treatment to people suffering from depression and anxiety [51]. The PPHC has set itself the task of recruiting more psychologists to the municipalities in Norway, concentrating on prevention and treatment of mental disorders [52]. It is worth noting that the title psychologist is used differently in Norway than in England. In Norway, the title psychologist implies a six-year university education in clinical psychology comprising theory and clinical training, followed by a professional authorisation (chartered psychologist) [53]. Studying to be a psychologist in England takes on average seven years [54]. Becoming a chartered psychologist in England is more extensive and entails society-accredited postgraduate qualifications and training and a research doctorate in psychology [55]. Alternatively the research doctorate can be replaced by an appropriate postgraduate training combined with experience of teaching psychology [55].

Our comparison of IAPT and PPHC will focus on the first three-year period of both initiatives. It is based on publicly available government documents such as propositions, reports, budgets and national guidelines, along with official web pages, documents from stakeholders and scientific articles. The documents and articles are retrieved from the

internet, primarily from official English and Norwegian web pages and the database ISI Web of Science.

IAPT and PPHC will be described and discussed along the following 15 points of comparison: 1. The organization of mental health services in England and Norway beyond IAPT and PPHC; 2. Main goals; 3. Target groups; 4. Interventions provided in the services; 5. Prevention of mental disorders; 6. Employees' education and clinical qualifications; 7. Inclusion and exclusion criteria for clients; 8. The political background of IAPT and PPHC; 9. Economic analyses and considerations prior to the implementation of the initiatives; 10. The evidence-base concerning the content of the services; 11. Strategy of implementation; 12. The scale of the initiatives; 13. National government and monitoring versus local autonomy; 14. Evaluation of the services and the initiatives as a whole; 15. Progress in the first three years. The points of comparison were generated during the review of relevant documents, and represent differences between the initiatives. An exception is the first point of comparison, examining the similarities between the Norwegian and English health care systems, which constitute a premise for the following comparison of IAPT and PPHC.

Discussion

1. The organization of mental health services in England and Norway beyond IAPT and PPCH

Both in England and Norway, the patients' first point of contact with the health care system is the general practitioners (GP) [56, 57]. The organization of the general practices in the two countries is similar in that the majority of the population is registered on patient lists, with the GPs being responsible for the patients on their lists [58-60]. Besides prescribing medication and consulting patients, the GPs function as gatekeepers to specialist services

where it is often necessary with a GP referral to be accepted [59]. Both in England and Norway, GPs are in frequent contact with people suffering from mental health disorders. In England, the NHS estimates that between a quarter and a third of a GP's workload is made up by emotional and psychological conditions [61]. In Norway, official statistics of the GPs' work shows that mental disorders are the most frequent cause for GP consultations among people between 15 and 44 years old [62]. This makes the GPs a prominent part of the health services available for people suffering from mental illness.

Concerning the organization of the health care systems in general, both systems are divided into primary and secondary care [63, 64]. Primary care is the responsibility of the primary care trusts (PCT) in England and the municipalities in Norway [64, 65]. In Norway, the mental health services in primary care vary between the municipalities, with some services being provided nationwide. In both countries primary care comprises the obligatory GP services, community mental health teams providing daily support to people with complex mental health conditions, crisis teams, as well as several services for children and young people [65]. The main focus of the mental health services in primary care has traditionally been directed at people with severe mental health problems in both countries [64, 66].

The secondary care services for mental health problems are provided by the Mental Health Trusts in England [63] and the regional health authorities in Norway [64]. The services provided includes inpatient care, community and rehabilitation services, day clinics, drop-in centres and psychiatrists and psychologists in private practices [64, 65].

While there has traditionally been a clear divide between primary care in the community and more specialized services for the severe cases of mental illness in both countries, there has been a shift towards a larger portion of the health care services being provided in primary care [67, 68]. IAPT and PPHC constitute two attempts to improve the

available mental health services in primary care, and to provide an alternative to treatment in the general practices. This involves an ambitious re-organization of the mental health care services in the two countries.

2. Main goals

The main goal of the IAPT programme is to greatly increase the availability of evidence-based psychological treatment for depression and anxiety disorders within the National Health Service (NHS) in England [69]. To accomplish this, the IAPT programme has set a goal of training and employing new psychological therapists within the NHS.

The PPHC programme's two main objectives are to stimulate an increase in the recruitment of psychologists to primary mental health care, and to implement and test different organizational models of the services [52, 70-72]. The models are: 1) Psychologists co-located with general practitioners, 2) Psychologists working in their own distinct municipal services, 3) Psychologists working in existing mental health services along with health visitors and community mental health nurses and 4) Psychologists working in Family Centres, where several health services are co-located.

The main goals of the initiatives are similar in that they both seek to strengthen the services offered in primary mental health care by increasing the qualified labour there. An important difference concerns the employees of the services. While the IAPT programme seeks to train and employ new therapists not previously employed in mental health care, the PPHC will draw exclusively on already trained psychologists. Therefore, the PPHC will most likely not constitute a significant effect on the number of mental health professionals employed in mental health services overall, since most psychologists are already employed within such services [73].

3. Target groups

The IAPT programme was initially targeted at people of working age suffering from depression and anxiety [74]. In 2010 it was extended to include adults of all ages suffering from these disorders [51].

The Norwegian Directorate of Health states that the PPHC programme should target children, adults and elderly people suffering from mild, moderate or severe mental disorders, as well as those with subclinical syndromes of mental illness [52, 72]. This entails a large target group with few limitations. In addition, the services offered should apply to individuals, families, next of kin, groups and local communities [52, 72]. This further contributes to increase the volume of the intended target group. Each municipality in the PPHC programme decides locally who their target groups are within the frames laid out by the directorate [52, 72].

A similarity between the two initiatives is that they both include adults suffering from depression and anxiety. The main difference is that the target group in PPHC is more comprehensive, and not limited to adults suffering from anxiety and depression. This comprehensiveness implies that most, possibly all, target groups a psychologist can work with fall within the frames laid out by the Norwegian Directorate of Health.

4. Interventions provided in the services

The content of the IAPT services is based on the recommendations for best clinical practice from the National Institute of Health and Clinical Excellence (NICE). They are intended to offer NICE-compliant psychological therapy services, thereby providing evidence-based treatment [75]. The NICE guidelines concerning CBT for the management of common mental

health problems issued in April 2008 recommends a stepped model of care for the management of depression, anxiety, and obsessive-compulsive disorder (OCD), with the exception of posttraumatic stress disorder (PTSD) [76]. A five step model is described by NICE, and the IAPT services are meant to provide treatment on the second and third level of the stepped care model, concerning treatment in primary care teams [44].

Several interventions are described for each of these steps in the IAPT implementation documents, divided into low-intensity interventions at the second level and high-intensity interventions at the third level [77]. The low-intensity interventions are mainly provided over the telephone and include computerized CBT, self-help, guided self-help, structured training and psychoeducation in groups. The high-intensity interventions include various kinds of face-to-face psychological treatment like CBT, interpersonal therapy, counselling and couples therapy [77]. Low-intensity treatment involves up to seven sessions, while high-intensity therapy can entail up to 20 sessions [75]. In addition to the psychological treatment provided by the IAPT services, they are meant to provide guidance on employment, housing and benefits to ensure an integrated and holistic service which tends to practical needs alongside the need for treatment [75].

One of the main objectives in PPHC is to try out different organizational models for psychologists working in primary mental health care. The intended content of these models, as described by the Directorate of Health [52, 72], is extensive. It comprises psychological treatment of mild, moderate and severe mental illness, continuous observation of people suffering from severe mental illness, rehabilitation, prevention of mental disorders utilizing individual-, family-, group- and population-based interventions, systemic work in the municipality, supervision of staff within the municipality, and multidisciplinary work [52]. This creates a framework for the psychologist to operate within, comprising therapeutic,

systemic and organizational work within the municipality, without further specification of the interventions. Although national guidelines for best clinical practice similar to the NICE guidelines have been developed in Norway, these are not included in the description of PPHC, and are not obligatory for the content and interventions used in the services [36].

The interventions found in IAPT can be included in PPHC since the descriptions of the intended content covers CBT with depression and anxiety disorders along with nearly all other possible aspects of a psychologist's work. The reverse is however unlikely since the IAPT interventions are limited to recommendations by the NICE guidelines, excluding all other interventions. Given the extensive number of interventions expected to be performed by PPHC, one can readily imagine the necessity for a psychologist working alone in a municipality to concentrate on certain interventions within the frames set out by the Directorate of Health, while disregarding others. It has been claimed that this vagueness can make the psychologists' work overwhelming and difficult to grasp, with a lack of predefined structure, clear frames and routines [78].

5. Prevention of mental disorders

PPHC has been described as a preventive psychological service [79], as well as a clinical treatment service [52]. One of the background documents of PPHC characterizes its goal of "easy access to treatment" as secondary prevention [80]. This is based on Gerald Caplan's differentiation between primary, secondary and tertiary prevention [81], and entails interventions practised after the onset of a disorder, but before it has caused suffering and disability [82].

Caplan's classification has been criticized for its focus on symptoms and the aetiology of a disorder [82-86]. An alternative definition of prevention, proposed by Robert Gordon jr.

and elaborated by others, emphasizes the importance of risk factors for developing a disorder [82, 85, 87, 88], and entails: "Interventions that occur prior to the onset of a disorder that are intended to prevent or reduce risk for the disorder" [88]. The interventions are classified on the basis of which population groups they are targeted at, and differentiates between indicated, selective and universal prevention, respectively targeted at individuals, subgroups of the population or the entire population [82, 88]. According to the Directorate of Health, PPHC should include interventions targeted at individuals, groups and the entire population [52], allowing for a wide range of preventive enterprises.

The use of preventive interventions is not mentioned in the description of the IAPT services, which focuses solely on treatment of mental disorders [75]. According to Caplan's definition of prevention, both PPHC and IAPT include secondary preventive interventions as they offer treatment in early stages of mental illness. However, the IAPT programme cannot be said to include indicative, selective or universal prevention, since IAPT consists of services offering treatment to people identified as having depression or anxiety disorders.

The difference between IAPT and PPHC lies mainly in the degree of freedom employees in the services have to do preventive work, which is greater in PPHC. We do not yet have any empirical knowledge of how psychologists in the PPHC initiative prioritize between clinical and preventive interventions, so the actual difference between the two initiatives can be small or none-existent regarding prevention of mental disorders.

6. Employees' education and clinical qualifications

While PPHC aim to increase the number of psychologists working in primary care, IAPT involves the education of a new workforce in mental health care. This workforce consists mainly of high-intensity and low-intensity therapists who work with interventions on

different levels in the stepped care model [75, 77]. The therapists in the IAPT services are described by their competences, either in high- or low-intensity work, since it is argued that proficiency at delivering psychological therapies is unlikely to be indicated by a job title or experience alone.

In IAPT, a national training course and curricula for high- and low-intensity therapists has been developed on the basis of a report describing the competences required to deliver effective CBT for depression and anxiety disorders [77, 89, 90]. Training for both high- and low intensity therapists involves a one-year course with a mixture of off-the-job training in a training institution and work in an IAPT service under supervision [75]. The training is provided by Higher Education Institutions commissioned by the Strategic Health Authorities (SHA) using the curricula developed for these therapists [91-93]. Supervision of the therapists is a key activity in IAPT, and there is developed a supervision guidance to ensure the quality of the supervisors [94].

To emphasize the focus on competences, the therapist roles in the IAPT services has deliberately not been tied to particular professions [95]. However, there are some specifications as to who can begin training within the two programmes. To qualify as a trainee in high-intensity therapy, one must have considerable experience and training in providing psychological therapies [91]. Clinical and counselling psychologists, nurses, primary care counsellors and other professional groups are eligible for the high-intensity training programme [75, 91]. The training is primarily aimed at postgraduates, but will also include graduate mental health workers with equivalent professional and academic experience [93]. The trainee low-intensity therapists can be drawn from a wide range of backgrounds, and includes those with an interest in therapy and relevant work experience [75, 91].

The supervisors might be educated in a range of professions, such as nursing, counselling, psychology and psychotherapy, and should be trained practitioners in the therapy they are supervising. They should also have previous experience in supervising psychological therapists or trainees [94]. Research on the workforce in the IAPT services indicates that a wide range of professions are represented in the IAPT workforce, in accordance with the specifications [95]. In addition to the therapists and supervisors, the IAPT services also include administrative staff and advisers on employment, housing and benefits [75].

While the employees in IAPT are not tied to any particular profession, the eligible employees in PPHC are exclusively psychologists. Though this constitutes a difference in employment between the initiatives, one would expect the psychologists working in PPHC to be eligible for high-intensity training posts within IAPT. The role of English psychologists in IAPT is not clearly described due to the focus on competences rather than professional titles, but according to the British Psychological Society, experienced clinical psychologists can without further training be employed as qualified staff in the roles of high intensity therapists, supervisors and programme managers [96]. Newly qualified psychologists are suited for the high-intensity training and therapist posts [97]. Thus, psychologists are likely to be found both in IAPT and PPHC and the competences of the employees in a service may be quite similar, apart from the lack of administrative staff and advisers on employment, housing and benefits in PPHC.

7. Inclusion and exclusion criteria for clients

The first contact with an IAPT service is based on a referral from a person's GP, other health services, or through self-referral. The person referred should receive an assessment by a

member of the IAPT team and be treated according to the NICE-guidelines, with the severity of the person's symptoms determining whether to commence high- or low-intensity treatment [75]. This entails that any adult suffering from depression or anxiety who can be treated at level 2 or 3 in the stepped model of care should receive an offer of treatment in their local IAPT service. Patients with mild depression and anxiety can be treated at level 2, while patients suffering from moderate to severe depression or anxiety that can be treated in a primary care setting are eligible for treatment at level 3 [44, 76]. Those who do not meet these criteria are excluded from the services.

Research on the progress made by IAPT services in the first year of the national roll-out indicates that the individuals reported to be unsuitable for the services, and thus not receiving treatment, required more intensive care than the service is meant to provide due to the complexity, co-morbidity or severity of their difficulties [98]. These individuals might need treatment on a higher level in the stepped care model, as described by NICE [44]. The research also shows that only 57.8% of the people referred to the services showed up for an initial assessment, indicating that a substantial part of those referred drop out before their first contact with the service [98].

The PPHC services are meant to provide "low threshold", or easy access, to mental healthcare in the municipality [52]. One of the aspects that define a "low threshold" service is access without the need of referral [80]. This indicates the use of self-referral in the services, although this practice varies between municipalities. When people get in touch with the PPHC service, either through a GP referral, referral from other health services or self-referral, it is the psychologist who decides whether or not treatment is offered. We have not been able to find a national overview or statistic on the number of people referred to,

and accepted in, PPHC services. There are no clear exclusion criteria described by the Directorate of Health [72].

A similarity in the inclusion criteria in IAPT and PPHC is that both are expected to accept self-referral to the services. This may lead to a more efficient and accurate assessment of the patients since it will be performed by mental health workers. Furthermore, it will relieve the GPs of some of their workload associated with the assessment and referral of patients to these services, which is requested by GPs as a way of improving the treatment of mental disorders in primary care [99]. While it is the psychologist who decides which patients to include in the PPHC services, it is not specified who should make the initial assessment in IAPT. However, Lord Richard Layard, one of the instigators of the IAPT services, describes the possibility for a senior therapist to make the initial diagnosis and assign the patient to an appropriate therapist at the appropriate level of treatment [100]. If so, the inclusion in both PPHC and IAPT services are based on assessment performed by personnel with extensive knowledge of mental health disorders, which increases the likelihood of a correct assessment. However, where there are clear criteria for the therapist to follow in the inclusion of patients in IAPT services, the inclusion criteria in PPHC are so broad it makes local prioritizing a necessity. The inclusion in the services will therefore depend on the choice of the therapist to a greater extent in PPHC, than in IAPT where the therapist must follow the predetermined criteria.

8. The political background of IAPT and PPHC

In 1997, the UK government initiated an ambitious renewal and modernization of the NHS [101, 102], followed by the publication of the National Service Framework for Mental Health [67]. In this framework it was argued that some specialist mental health services should be

offered in a local setting, thereby moving the responsibility from secondary to primary care [67]. This shift in responsibility was accompanied by the governments clear intent to give mental illness a higher priority than had previously been the case, and extra funding was provided for the reshaping of mental health services in the communities [67]. In 2006, the White Paper: "Our Health, Our Care, Our Say" [103] emphasized the importance of prevention and early intervention in the health care services, and described a radical shift towards an increasing amount of services being provided locally, in primary care settings [103].

The IAPT initiative was formulated building on these political changes. A general political commitment to increase the availability of psychological therapies was gained in 2005 [69]. The political decision was based on the arguments for IAPT professed by Lord Richard Layard among others [104], and it has been claimed that his personal contact with central politicians was especially important in securing political support for IAPT [105].

Before deciding on the scale and form of IAPT, it was decided to carry out two pilot projects in order to evaluate whether the services would be as effective as anticipated. Following the successful outcomes of the pilot sites [106], in October 2007 the government announced an allocation of £170 million to build IAPT services throughout the country by 2010/2011 [107]. The funds were allocated from the Comprehensive Spending Review 2007, where improving access to psychological therapies were made a priority of the government, formulated in regional performance indicators [108].

The political background of PPHC is closely related to that of community psychologists in Norway. In the 1970s-1980s, there were community psychologists working with treatment and prevention of mental disorders in several Norwegian municipalities [109]. In the years 1978-1984 the "Act relating to municipal health services" and several

official committees prescribed that psychologists should be a part of the specialist mental health services, and not an obligatory part of primary health care [109, 110]. One effect of this was that the PPHC-like services from the 1970s-1980s never became a nationwide part of primary health care.

In the years 2000-2010 there was a renewed focus on mental health care, and the Ministry of Health and Care Services called for an increase in the number of psychologists recruited to primary health care [111]. The Norwegian Directorate of Health includes two political documents from this time period as part of their description of PPHC, namely the "Escalation Plan for Mental Health 1999-2008" and the "Coordination Reform 2008-2009" [68, 70, 112]. These political documents call for an increase in the resources spent on mental health services, and the relocation of services and funds from specialist to primary health care [68, 112].

One of the subsidiary goals of the "Escalation Plan for Mental Health" was to strengthen primary mental health services in the municipalities by increasing the number of psychologists employed there. When the "Escalation Plan" period came to its conclusion, it became clear that this goal would not be met [113]. As a consequence the Directorate of Health initiated the work on the PPHC incorporating some key elements from the "Escalation Plan for Mental Health" [80, 114] and the "Coordination Reform 2008-2009" [68]. These elements are prevention, early intervention, easy access to treatment and an upgrade of the municipalities responsibility and competence concerning mental health services [70],

The political backgrounds for IAPT and PPHC are very similar. The bases for both initiatives are political decisions prescribing an increase in mental health services in primary health care. This includes relocating funds, services and responsibility from secondary to primary care. One difference between the two is the emphasis on prevention in the

formulation of PPHC, while the English government's focus is improving access to psychological therapies, that is to say treatment. Regarding the political anchoring for the initiatives, it seems that this is placed at a higher level in England than in Norway. The English government clearly expressed their commitment to IAPT, and made it one of the government's priorities. In Norway, we have not been able to find such clear intents from the government.

9. Economic analyses and considerations prior to the implementation of the initiatives

One of the main arguments that persuaded the British government to commit to IAPT was that an "...increase in access to psychological therapies would largely pay for itself..." [69]. Drawing on research on the efficacy of psychological treatment and its impact on employment and absenteeism, the instigators of IAPT published analyses of the economic costs and benefits of providing psychological therapy to those who had no such alternative available [100, 104, 115]. They found that the treatment would pay for itself due to reductions in public costs, such as welfare benefits and medical costs, and increasing revenues associated with taxes from return to work and increased productivity [115]. They argue that the fundamental reason why therapy is economically profitable is the balance between the high cost of a person on incapacity benefits, costing £750 a month, and the low cost of treatment per person, costing £750 altogether [115]. These arguments were also advanced in a report widely distributed throughout the country [104], with a finishing note requesting people to demand implementation of the NICE guidelines for anxiety and depression, thereby increasing the pressure on policy makers [69].

After political consensus was reached, and before the nationwide implementation of IAPT, an impact assessment of IAPT was conducted for the Department of Health, with three

different policy options being considered. The assessment describes in detail the possible costs, benefits and impact of doing nothing, of implementing IAPT with increasing investments over 6 years, and of implementing IAPT with investments increasing over three years and remaining stable after this period [116]. The assessment contains a detailed analysis of the expected economic costs and gains of the different implementation strategies, providing political decision-makers with evidence on which to make their decision.

We have not been able to find economic analyses or assessments in the official documents or web pages describing the Norwegian initiative. A possible explanation is that PPHC is considered to be a relatively small investment, which is exclusively meant to cover part of the newly recruited psychologists' salaries. The lack of economic analysis might result in political decisions being made on insufficient grounds, without addressing the cost-benefit of the initiative or alternative solutions.

10. The evidence-base concerning the content of the services

The evidence-base concerning the content in IAPT services is concurrent with the evidence-base for the NICE guidelines, more specifically the guidelines for depression and anxiety disorders [44-46, 117]. NICE was developed to ensure high quality in NHS services by reporting which treatments work best for which patients on the basis of available research, and is internationally recognized for its high quality [118, 119]. The guidelines are developed by several independent committees, and are based on the best evidence available [120]. The evidence is classified into a hierarchy with five levels adapted from the US Agency for Healthcare Policy and Research Classification [44]. Level 1 evidence stems from randomised controlled trials, either a single study or meta-studies. Level 2A involves at least one well-

designed controlled study without randomization, and 2B at least one quasi-experimental study. Evidence at level 3 is obtained from well-designed non-experimental descriptive studies, and level 4 includes evidence obtained from expert reports or opinions [44].

The organization of the IAPT services has been informed by research on the pilot projects carried out prior to the national roll-out [106, 121]. In 2006, two pilot sites, Newham and Doncaster were funded by the Department of Health to investigate whether the IAPT programme would show the expected effects [69] and to inform the development of services nationwide. The sites, called demonstration sites, showed encouraging results [69]. Following the experiences made in the demonstration sites, the use of self-referral and a session-by-session outcome monitoring system was incorporated in the national roll-out of IAPT services [106].

Following the positive outcomes of the two pilot sites, 11 pathfinder sites were initiated in summer 2007. Their aim was to expand the model of care piloted in Newham and Doncaster to meet the needs of the whole population, including particular groups such as children and minority ethnic groups [122]. Based on the experiences from the pathfinder sites, it was recommended that IAPT services develop strategies to actively pull in referrals and develop patient information about the services to be widely distributed in the community. It was further recommended to use appropriate technology to support data collection, and to perform local needs assessments and assessment of workforce to match the capacity of the services to the demands of the population [123]. In addition, the pathfinder sites informed the publication of a report which provides positive practice guides to PCTs on meeting the needs of the whole community, with equal services to all [123, 124].

The evidence-base for PPHC mainly stems from two expert committees consisting of representatives from different trade unions and political bodies [80, 114]. The committees'

conclusions are summarized in a report from the Norwegian Directorate of Health [80]. The evidence referred in the report is mainly gathered from non-experimental descriptive studies, correlation studies and case studies [114, 125].

The use of government funding as an economic incentive to stimulate an increase in the recruitment of psychologists is based on an evaluation of "The Escalation Plan for Mental Health" [113]. The evidence is based on two non-experimental descriptive studies, and states that economic incentives are an effective method for increased recruitment [113, 125]. The four organization models of the psychologists' work constitute another central part of the PPHC initiative. The development of these models seems to be based mainly on pragmatic considerations, and we have not been able to find references to studies examining the effect of the different organizational models in the descriptions of PPHC.

The intended content of the PPHC services is extensive, and the underlying evidence reported in the official documents and reports is of varying quality. One of the tasks described as relevant for psychologists working in primary mental health services is the prevention of mental disorders. The inclusion of prevention of mental disorders in the description of PPHC is based on a meta-analysis where the majority of the studies reviewed used a randomized design [126], and a less structured review of literature on prevention of mental illness and mental health problems [86]. These studies report that prevention of mental illness through different programmes significantly reduces problems and increases competencies in children and adolescents [126] and have positive effects on mental health indicators for both children, adolescents and adults [86]. We have not found references to research concerning the other PPHC interventions, such as treatment, rehabilitation and supervision, in the official documents.

The emphasis on scientific evidence is greater in IAPT than in PPHC. In addition to research forming the basis for the interventions in the services, the IAPT project was piloted and research was carried out on the IAPT services before the full implementation. There is no such research on, or evidence for, the PPHC initiative. Compared to IAPT, PPHC appears rather like a pilot project than a full scale implementation.

Taking into account the hierarchy of evidence adapted from the US Agency for Healthcare Policy and Research Classification, it is clear that IAPT not only has a more extensive evidence-base than PPHC, a greater portion of this evidence is found at higher levels in the hierarchy. In PPHC, most evidence is located at level 4, with one meta-analysis at level 1. However, this meta-analysis is not used to inform the development of the services; it is simply used to indicate that preventive interventions can be effective. In the evidence-base for IAPT there is evidence at all levels in the hierarchy. Although most evidence is found at level 3 and 4, a greater proportion of the evidence is located at level 1 in IAPT than in PPHC.

The difference between the evidence-base for IAPT and PPHC might partly be due to the intended contents of the services. Since IAPT aims to provide a limited range of solutions, interventions, for a limited range of problems, mainly depression and anxiety disorders, it is feasible to develop it according to evidence on treatment of these disorders. In contrast, PPHC involves such a wide range of problems, and possible solutions to these, that it would be difficult to collect evidence for all aspects of the services and incorporate this into the development of the initiative.

Scientific evidence was also an important factor in the political decision to commit to IAPT. Besides the economic arguments that were imperative to attain political consensus for IAPT, the ability to document the effects of structured psychological treatment was

important [105]. This does not seem to be the case in PPHC, where the recruitment of psychologists appears to be the main aspect.

11. Strategy of implementation

Following the experiences from the two demonstration sites and the 11 pathfinder sites, a national implementation plan for IAPT was published in February 2008 [75]. In addition to the development of IAPT services, the implementation includes a training programme for the future IAPT workforce which entails practical training within an IAPT service. To ensure that the training places met the high standards required from the beginning, it was decided that a limited number of PCTs would develop IAPT services during the first year of the roll-out. Thus, a minimum of 20 PCTs were required to develop services during the first year 2008/2009. Each of the 10 SHAs in England chose participant PCTs on the basis of several selection criteria. These include an assessment of the needs of the PCT population, enough qualified therapists in the service to meet this need, one-third of the therapists working in the services being fully trained, and demonstration that the PCTs would not reduce the funding of other, pre-existing therapy services [75].

The following two years, august 2009- august 2011, the full national roll-out took place [98]. The development of the IAPT services was supported by the implementation plan [75] along with a number of support documents describing different aspects of the services. They provided an overview of the local commissioning of IAPT [77], the required competences among the employees in the services [90], how to collect outcome data [116], and guidance for supervisors [94].

In Norway, the Directorate of Health announced the subsidy for PPHC in 2008 and published a description of the objectives for the subsidy along with an application form [70,

127]. The application forms are completed by the municipalities, and must include a description of the interventions or projects that will be financed by the subsidy, the amount one applies for, the budget, financing from the municipalities, and internal and external measures to ensure that the goals are met and the results reported as requested.

There are no absolute criteria for the allocation of funds, and the section of municipalities to receive the subsidy is purely discretionary [70]. The subsidy is given for one year at a time, and can be given up to three years. It is gradually reduced from a maximum of NOK500,000 (£52,002) the first year to a maximum of NOK250,000 (£26,001) the third year, and it is expected that the municipalities will increase their funding accordingly [70]. Even the maximum NOK500,000 subsidy does not cover the costs of employing a psychologist, indicating a substantial need for municipal funding. When municipalities are granted funds for PPHC, they start the process of hiring a psychologist. With a psychologist successfully hired, the services are developed. If the municipalities cannot find a psychologist to work in the PPHC service, the funds must be returned since the criteria for the subsidy are not fulfilled [72].

The differences between the implementation strategies of IAPT and PPHC are the level of specification from the funders, the scale of the implementation, and the selection criteria for the PCTs and municipalities. Where there exist a large number of support documents describing how to develop an IAPT service, there is only one document describing the envisaged content of the PPHC services. Though it can be an advantage to gather all relevant information in one document, the seven paged PPHC document does not specify the implementation further than the general framework for the services. Therefore, the developed services are likely to be more similar in IAPT than in PPHC, since the intended form of the services is described in detail and there is little freedom for the services to

deviate from these descriptions. This contributes to a national coordination of the services developed throughout the country.

The scale of the implementation is greater in IAPT than in PPHC. In IAPT, all PCTs in the country are included from the second year of implementation, while there are currently no plans for PPHC to cover all the municipalities in Norway. This also entails a greater need for local initiative in PPHC, where the application for participation in the project is voluntary and participation will not be available to all. Since the PPHC service will draw on the resources of the municipalities as well as the funded resources from the government, local economy may be an important determinant of the distribution of PPHC services throughout Norway.

In addition to the difference in the number of services being developed, the services themselves are more extensive in IAPT than in PPHC. The funding of IAPT is used to develop therapy services with a number of therapists, supervisors and administrative employees in place, while the funding of PPHC covers the hiring of one psychologist at a time.

Regarding the selection criteria of the services, the criteria for PPHC services differs from the criteria found in IAPT by focusing on the interventions in, and the economy of the services, rather than the needs of the population and whether these needs can be met by the services. Although there are selection criteria for both the participating IAPT and PPHC services, these criteria only applied in the first year of the roll-out of IAPT. The following two years, when the goal was to develop services in all 152 PCTs in England, it is likely that the PCTs were instructed to develop such services rather than to apply for participation. This shift in the implementation strategy, from suitability determining the participants to all being accepted, would be necessary in order to reach a nationwide implementation in only two years. With no criteria for participation, the PCTs who develop IAPT services are likely to

vary in their suitability, making clear regulations and continuous evaluations of the services increasingly important. In contrast, all new municipalities wanting to receive PPHC funding must send in an application throughout the three-year period.

12. The scale of the initiatives

The scale of the IAPT programme for the 2008-2011 period includes an investment of £309 million and the education of 3,660 new therapists [69, 75]. By spring 2011, IAPT services have been established in 95% of PCTs, and around 60% of the population has access to an IAPT service [69]. These services are currently seeing 310,000 patients per annum [69].

Ambitions for the 2011-2015 period of the IAPT programme includes a further investment of £400 million and the education of 2,400 new therapists [69, 128]. The aim is to treat 900,000 people per annum by 2015, and be accessible to 100% of the population [128]. The IAPT services are to be extended to cover several new groups such as: children and young people, those with physical health long-term conditions and mental health issues, those with medically unexplained symptoms and those with severe mental illness [128].

The investment for PPHC was NOK90 million for the 2008-2011 period (£9.3 million), and 108 psychologists were recruited in this period. In 2011 there were PPHC psychologists working in 109 of 429, or around 25%, of the municipalities in Norway [129]. We have not found any calculations concerning the number of people with access to PPHC services, or how many patients PPHC psychologists are seeing each year.

In 2012, PPHC was extended for another year, and an additional NOK40 million (£4.2 million) were granted, estimated to fund the recruitment of 20 new psychologists within the year [130]. We have not found any documents addressing additional future ambitions for PPHC. Since it is expected that the municipalities will increase their funding as the

government funding decreases, one can safely assume that the municipalities will continue to pay in full for their PPHC services when the government funding is terminated. It is also worth noting that a pilot project based on the experiences from IAPT in England will be initiated in one Norwegian municipality in 2012 [131].

It is difficult to compare the scale of the IAPT and PPHC initiatives, mainly due to the scarce information on the scale of PPHC. Given the number of therapists in IAPT and PPHC, we can formulate a proportional estimate based on the premise that IAPT is serving its original target group and PPHC is serving a target group of a proportionally similar size.

IAPT services treated 310,000 people per annum for the first three-year period [69]. If we divide the number of people treated, 310,000, with the average total population size in England in the given three-year period, 51,836,100, we find that IAPT served 0.6% of the population per annum in the years 2008-2011. Given that PPHC has the same target group as IAPT, we multiply the average total population size in Norway for the same period, 4,859,252, with 0.6% which equals 26,060. This means that PPHC services would have to serve 26,060 people per annum to match IAPT's target group.

Given 3,660 IAPT therapists serving 310,000 people, and 108 PPHC psychologists serving 26,060 people, we get the following estimation of the proportions of the initiatives: (3,660/310,000) / (108/26,060) = 2.8. Given this premise the IAPT initiative is about 2.8 times the size of PPHC in terms of a therapist/target group ratio.

There are some conditions regarding the estimation worth noting. While IAPT has treated 900,000 people the first three years, it has also educated 3,660 new therapists and developed an entirely new service in many PCTs. Where pre-existing services have formed the basis for an IAPT service, the implementation of IAPT has involved a fundamental

restructuring of the existing services. The number of people treated is therefore not a completely valid representation of the true scale of IAPT, which should probably be larger.

The PPHC on the other hand uses already trained psychologists, and some municipalities have pre-existing community psychologist services where these psychologists are employed without making any further organizational changes. PPHC's target group is considerably larger than IAPT's as it entails all people suffering from mental disorders and subthreshold syndromes of mental disorders, as well as including prevention of mental disorders [72]. Taking PPHC's larger target group into account, the difference in scale between the two initiatives is probably greater in favour of IAPT, making IAPT more than 2.8 times the size of PPHC.

In the comparison of the scale of the initiatives, it becomes clear that IAPT has more resources directed at a limited target group, and PPHC has fewer resources directed at a much larger target group. This enables IAPT to serve 60% of its target group by the year 2011, an estimate increasing to 100% by the year 2015 [69]. There are no such estimates for PPHC, and given the limited resources distributed to a large target group, one can safely assume that it only serves a fraction of the intended target group. Put in simple terms, the size of the target group in PPHC is not in accordance with the resources available. However, if PPHC could focus all its resources on working with risk factors and preventing mental disorders, and minimize the time spent on psychotherapy with individuals, this might have a positive effect on the scale of the initiative. This is based on the assumption that the limited resources in PPHC could be utilized on larger groups of people, giving less benefit to each individual, but greater benefit to society as a whole.

13. National government and monitoring versus local autonomy

Before the nationwide implementation of IAPT it was argued that a strong lead from the Department of Health in the initial phases of the roll-out would be an important means to ensure the quality of the therapy provided [100]. This argument was supported by the experiences made by the demonstration sites in Newham and Doncaster which focused either on high- or low-intensity therapy, and therefore did not implement the stepped model of care recommended by the NICE guidelines. It thus became clear that central governance and clear national standards were necessary for the NICE guidelines to be followed consistently in the IAPT services in the full roll-out [106].

As a result, there is a high degree of national governance in IAPT, with the main aspects of the services predetermined by central authorities. The organization and running of the services, as well as the training programmes for the new therapists was specified by a number of expert groups appointed by the Department of Health [69]. The work of the expert groups resulted in a national implementation plan to support the local delivery of IAPT [75], and several support documents that further specify the organization of the services, leaving little room for local variations in key aspects of the services [77, 124, 132].

IAPT is administered according to the NICE guidelines, and the national specifications are meant to support local development of NICE compliant services. This entails that new guidelines for the services will be issued when the NICE guidelines are revised and changed [75]. Although many aspects of the services are determined centrally, the exact configurations are meant to be agreed locally [75]. It has also been stated that the need for central control will diminish when the IAPT services are fully established according to the national guidelines, making a more decentralized governance of IAPT possible [104].

In addition to the national documents specifying the nature of the IAPT services, the commissioning of IAPT is controlled by a hierarchy of expert and programme groups. On the

top resides the National Programme Board which ensures that IAPT services operate in alignment with the instructions from the Directorate of Health and the Government. At the next level there is an expert reference group and a programme management group, each with several underlying groups with clearly specified fields of responsibility, such as education and training [128]. The performance of the IAPT services is monitored and reported on four different levels, ranging from national to local monitoring. The outcome measurements obtained in the individual services inform them on their progress and is reported to the PCTs who monitor the local performance of the services within their area of responsibility. The PCTs report to the SHAs who monitor the status of the regional commitments and report to the central programme board that monitors the status of the national commitments, ensuring that they are achieved [128].

In the governance of the PPHC services, there is a high degree of local autonomy. The guidance for development of the services issued by the Norwegian Directorate of Health comprises such an extensive variety of interventions that it functions like a framework for the services rather than clear national standards [72].

Regarding the monitoring and control of PPHC, it is obligatory for the municipalities who are a part of the initiative to complete a form for status report once every year while they receive funding for the service. They report on whether the municipality has succeeded in hiring a psychologist, which organizational model the psychologist works within, the visibility of the service, the individual-, family-, group-, and population-based interventions used by the psychologist, the financing of the services and their future goals [127]. The status reports are revised by the Directorate of Health who performs the central monitoring [127]. The municipalities are also required to account for internal and external supervision

precautions, such as internal audit and reports to the Office of the Auditor General of Norway [72].

While the IAPT services are subject to central governing and control, the PPHC services have a greater degree of local autonomy. This difference between IAPT and PPHC is also evident in the respective healthcare systems in general. The emphasis on central governance in IAPT and local control in PPHC can be traced back to the differences in the respective governments' politics. In England, the modernization process of the NHS the past 15 years has led to an increasing focus on national standards, central support of local services and measurement of progress in all health services [67, 101]. In contrast, a central aspect of the Norwegian healthcare system is an emphasis on local governance in the municipalities. In Norway, the municipalities have the overall responsibility for the healthcare services, and it is the government's intent that each municipality choose how to organize their services on the background of local circumstances and needs within the frames set out by laws and regulations [60].

A likely result of these differences in the healthcare systems in general, and in IAPT and PPHC services in particular, is that while IAPT services are quite similar in their organization and functioning, there exists a greater variety between PPHC services. This could also entail a varying degree of quality between the PPHC services, where quality depends on local initiative and the competences of the individual psychologist working in the service. Thus, while PPHC has the advantage of incorporating local knowledge and circumstances in the locally developed services, IAPT has the advantage of central commissioned quality control, providing them with a broader knowledge and evidence-base to build their services on.

14. Evaluation of the services and the initiatives as a whole

The achievements of IAPT are evaluated according to three headline outcome indicators set out by the Secretary of State. First, a minimum of 20 PCTs should implement IAPT in 2008/09, with increasing coverage over the subsequent two years. Second, 3,600 new therapists should be trained by 2010/11, and third, 900,000 people should receive treatment, with half of those completing treatment moving to recovery and 25,000 fewer on sick pay and benefits by 2010/11 [75]. The outcome indicators are clearly formulated and operationalized in a manner that makes it easy to evaluate the progress, and report this to the health care commissioners [132].

The foundation of the evaluation is routine data collection of patient status and progress, which is a key characteristic of the IAPT services [132]. Following the impressive data completeness from the demonstration sites which used a session-by-session monitoring system, a part of the recommended data set is mandatory for all IAPT sites receiving central funding [132]. The data set includes scores on measurements for depression and anxiety, employment status and disorder specific measures if appropriate [132]. This session-by-session monitoring system is fundamental in delivering a stepped model of care, where knowledge of the patient's progress determines the adjustment of further treatment [77]. It also helps the service providers improve their services, thereby improving people's benefits from treatment in IAPT. Another positive effect of the outcome monitoring is the high degree of data completeness, which is essential in evaluating IAPT and reporting the effects of the project to the government. Several evaluations of the progress of IAPT have been published based principally on these data [98, 106, 128].

Evaluation of the IAPT services is also incremental for the continuation of the project and continued government support. From the outset it was clear that a large scale

implementation and funding of IAPT depended on the outcomes in the demonstration sites [69]. As well as determining the future of the IAPT project, evaluations of individual services are used to improve those services who do not meet the expected patient throughput and recovery [132].

The main goal of PPHC is to increase the number of psychologists working in the Norwegian municipalities, which is easily determined. However, the goal was not quantified from the outset of PPHC, making evaluation of goal attainment difficult. In 2010, the Department of Health estimated, based on the experiences from the first two years of the initiative, that 110 new psychologists would be recruited by 2011 [133].

Another central goal is the implementation and testing of different organizational models for the services, which is another goal without clear evaluation criteria. There are also a number of criteria for goal attainment of the individual services, which the municipalities are supposed to report on each year. The report consists of a written reply to 10 questions regarding the organizational and structural aspects of the services, such as the psychologist's job description, whether the psychologist are involved in multidisciplinary work and supervision of other health care workers and how the psychologist's position is incorporated into the municipal organization [127]. The municipalities report on these criteria to the Directorate of Health. If the municipality reports incorrect information or the subsidy is not used according to the prerequisites, the funding can be terminated [70].

Based on the diffuse criteria of the PPHC one can wonder whether the presence of a few newly recruited psychologists who work within each of the four different models is enough to call the project a success. Although the goals of the PPHC are not clearly formulated and there is a lack of evaluation criteria, the effects of PPHC are currently being evaluated by two Norwegian research organizations, SINTEF and the Work Research

Institute, on behalf of the Directorate of Health. They are conducting interviews with the psychologists working in the municipalities and their collaboration partners, and have sent out a survey to all psychologists employed in municipal services. They are investigating the effect of the different organizational models on the work of psychologists in the municipalities, whether the recruitment of psychologists has increased and how the different models contributes to coordination with other services and professionals [134]. This research will be concluded in December 2012 [135].

Both in IAPT and PPHC it has been clear since the beginning that the continuation of the programmes, with additional funding from the government, depends on the outcomes of the first three-year period [133]. While the main focus on the evaluation of IAPT is based on patient outcome and the effectiveness of the services, the evaluation of PPHC focuses on organizational and structural aspects of the services. There is currently no research on how PPHC affects the inhabitants of the municipality and their psychological functioning, and we do not know of any plans to conduct such research. Since there is no system in place to collect data on the effectiveness of the services, or the health status of the target group, it is not evident how such research could be accomplished.

While the importance of evaluation is emphasised in IAPT, in PPHC it was not clear from the beginning whether, let alone how, evaluation of the services would be conducted. In the regulations of PPHC it is stated that there would be an on-going consideration by the Directorate of Health and the Ministry of Health and Care Services as to whether PPHC should be evaluated [70]. Thus, no systematic evaluation was planned from the outset of PPHC, in contrast to the emphasis placed upon evaluation in IAPT.

15. Progress in the first three years

More than 3,660 new therapists have been trained and employed in IAPT services throughout England [69]. There are 730,485 people who have entered treatment, and 432,208 have completed their treatment [128]. About 40% of those completing treatment moved on to recovery and 28,133 moved off sick pay and benefits. In the second quarter of 2011 around 60% of the population had access to an IAPT service [69, 128].

In the third quarter of 2011, 108 psychologists have been recruited to PPHC services in 25% of the municipalities in Norway [129, 130]. We have not found any documents concerning other aspects of the progress in PHCC relevant for this comparison.

Summary

The IAPT initiative is characterized by thorough planning of, and a solid evidence-base underlying, most aspects of the services. The on-going systematic evaluation of clinical and functional outcomes facilitates continuous improvements of the services. PPHC lacks all these qualities, but has the potential advantage of including indicative, selective and universal prevention in addition to clinical services. I theory, prevention can entail a more cost effective way to improve the mental health of the population than clinical services [136].

This advantage, however, is in jeopardy since the PPHC programme does not supply the recruited psychologists with the necessary tools to initiate and carry out preventive interventions. Psychologists are, in Norway as in most other countries, traditionally focused on, and educated for, clinical work. Unlike IAPT, there is considerable local autonomy in PPHC, and it remains to be seen if this autonomy will facilitate clinical work or prevention.

In conclusion, the only possible advantage of PPHC over IAPT is the potentially higher cost-effectiveness in the use of indicative, selective and universal prevention rather than clinical work. As the current organization of PPHC does not include any systematic evaluation

of improvement in the mental health of the target groups, we will never know whether PPHC is a success or not.

List of abbreviations

CBT – Cognitive Behavioural Therapy

GP – General practitioner

IAPT – Improving access to psychological therapies

NHS – National Health Service

NICE – National Institute for Health and Clinical Excellence

PCT – Primary Care Trusts

PPHC – Psychologists in primary health care

SHA – Strategic Health Authority

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

KG and JEH have been equally involved in all stages of the manuscript process. Both authors have read and approved the final manuscript.

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In press article
Kharitonov SA, Barnes PJ: **Clinical aspects of exhaled nitric oxide.** *Eur Respir J*, in press.

Published abstract
Zvaifler NJ, Burger JA, Marinova-Mutafchieva L, Taylor P, Maini RN: **Mesenchymal cells, stromal derived factor-1 and rheumatoid arthritis [abstract].** *Arthritis Rheum* 1999, **42:**s250.

Article within conference proceedings
Jones X: **Zeolites and synthetic mechanisms.** In *Proceedings of the First National Conference on Porous Sieves: 27-30 June 1996; Baltimore.* Edited by Smith Y. Stoneham: Butterworth-Heinemann; 1996:16-27.

Book chapter, or article within a book
Schnepf E: **From prey via endosymbiont to plastids: comparative studies in dinoflagellates.** In *Origins of Plastids. Volume 2.* 2nd edition. Edited by Lewin RA. New York: Chapman and Hall; 1993:53-76.

Whole issue of journal
Ponder B, Johnston S, Chodosh L (Eds): **Innovative oncology.** In *Breast Cancer Res* 1998, **10:**1-72.

Whole conference proceedings
Smith Y (Ed): *Proceedings of the First National Conference on Porous Sieves: 27-30 June 1996; Baltimore.* Stoneham: Butterworth-Heinemann; 1996.

Complete book
Margulis L: *Origin of Eukaryotic Cells.* New Haven: Yale University Press; 1970.

Monograph or book in a series
Hunninghake GW, Gadek JE: **The alveolar macrophage.** In *Cultured Human Cells and Tissues.* Edited by Harris TJR. New York: Academic Press; 1995:54-56. [Stoner G (Series Editor): *Methods and Perspectives in Cell Biology,* vol 1.]

Book with institutional author
Advisory Committee on Genetic Modification: *Annual Report.* London; 1999.

PhD thesis
Kohavi R: **Wrappers for performance enhancement and oblivious decision graphs.** *PhD thesis.* Stanford University, Computer Science Department; 1995.

Link / URL
The Mouse Tumor Biology Database [http://tumor.informatics.jax.org/mtbwi/index.do]

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Appendiks 2

UNIVERSITY OF BERGEN
Research Centre for Health Promotion, Faculty of Psychology

Det psykologiske fakultet
Universitetet i Bergen

Bergen den 29. mars 2012

Vedrørende hovedoppgaven til Jon Erling Heggland og Kristin Gärtner våren 2012

I henhold til emnebeskrivelsen for hovedoppgaver i psykologi har Heggland og Gärtner skrevet en hovedoppgave på artikkelformat. Den er formatert for innsendelse til journalen BMC Health Service Research, og studentene vedlegger retningslinjene for manusformatet i BMC HSR ved innlevering. Manuset vil bli innsendt til denne journalen innen mai 2012, og vil videreutvikles etter ytterligere bidrag fra veileder, eventuelle andre bidragsytere, eventuelt også etter tilbakemeldinger fra sensorer.

Studentenes hovedoppgave er en utredning, noe emnebeskrivelsen åpner for på linje med empiriske eller teoretiske hovedoppgaver. Heggland og Gärtner ble presentert for hovedoppgaveideen av meg som veileder. De har selv videreutviklet prosjektideen, utarbeidet flere utkast til disposisjon av hovedoppgaven, de har selv skaffet litteratur og andre kilder og satt seg inn i denne på egenhånd, og de har på selvstendig grunnlag utarbeidet alle artikkelutkast. De har fått muntlig og skriftlig veileding på i denne prosessen, men jeg har som veileder ikke skrevet noe av det som nå innleveres som hovedoppgave.

Hovedoppgaveprosjektet er assosiert med et prosjekt finansiert av Helsedirektoratet om kommunepsykologer, og Gärtner og Heggland er tilsatt ved Folkehelseinstituttets avdeling for Samfunn og psykisk helse i Bergen på dette prosjektet. Hovedoppgaven er imidlertid et selvstendig arbeid i forhold til prosjektet for Hdir, og de har ikke mottatt lønnsmidler for arbeidet med hovedoppgaven. Deler av hovedoppgaven vil imidlertid kunne brukes som kunnskapsbakgrunn i rapportering til Helsedirektoratet høsten 2012 i anledning en forestående empirisk intervjuundersøkelse blant kommunepsykologer.

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