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Improving Access to Psychological Therapies

NHS

Improving Access to Psychological Therapies: Science, Policy and Economics

David M Clark

English National Clinical Advisor for IAPT

Kings College London & University of Oxford

What is IAPT?

An English Programme that aims to vastly increase the availability of effective (NICE recommended) psychological treatments for depression and all anxiety disorders by:

- training a large number of psychological therapists
- deploying them in specialized, local services for depression and anxiety disorders

How did it come about?

A Brief History

2004

- Publication of NICE Guidelines for Depression and Anxiety (panic & GAD)

2005

- Cabinet Office Seminar (Layard, Clark et al)
- General Election Manifesto Commitment

2006

- Doncaster & Newham Demonstation sites established
- Public Campaign
  - *Depression Report* (published in Observer June 2006)
  - We Need to Talk (published by Mental Health Charities)
- National Economic Review Article (Layard, Clark, Knapp, Myraz)

The IAPT Argument (Depression Report 2006)

- Much current service provision focuses on psychosis which deserves attention but affects 1% of population at any one time.
- Many more people suffer from anxiety and depression (approx.15% at any one time. 6 million people).
- Economic cost is huge (lost output £17 billion pa, of which £9 billion is a direct cost to the Exchequer).
- Effective psychological treatments exist. NICE Guidance recommends CBT for depression and ALL anxiety disorders plus some other treatments for individual conditions (EMDR for PTSD, Interpersonal Psychotherapy, Couples therapy, Counselling & Brief Dynamic Therapy for some levels of depression).
- Less than 5% of people with anxiety disorders or depression receive an evidence based psychological treatment. Patients show a 2:1 preference for psychological therapies versus medication
- Increased provision would largely pay for itself

The Economics

(Layard, Clark, Knapp & Mayraz, 2007).

Cost (per patient)	750
Benefits to Society	
• *Extra output*	*1,100*
• *Medical costs saved*	*300*
• *Extra QALYs*	*3,300*
• Total	4,700
Benefits to Exchequer	
• *Benefits & taxes*	*900*
• *Medical costs saved*	*300*
• Total	1,200

Demonstration Sites:Newham & Doncaster.

- Awarded £1.5- £2 million per annum to increase access to psychological treatments (includes special set-up)

- Stepped care
  * Least burden principle
  * Psychological Well-Being Practitioners, HI intensity therapists & employment advisers

- Session by session outcome monitoring

- Experiment with self-referral

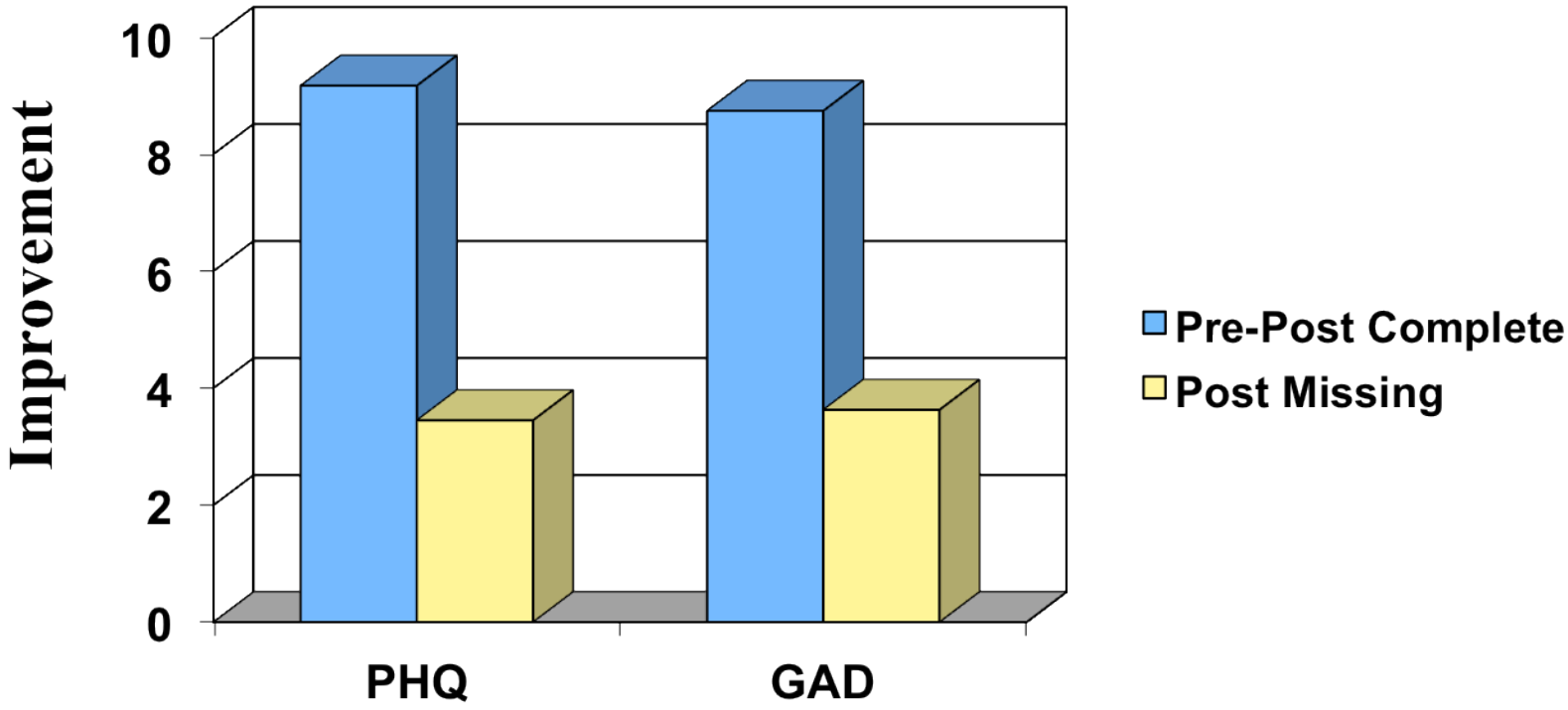
Demonstration Sites: First Year Results

(see Clark, Layard,Smithies, Richards et al. (2009) *Behav. Res & Ther*)

- Excellent data completeness (99% in Doncaster, 88% Newham).
- Large numbers treated (approx 3,500 in first year). Use of Low intensity important.
- Outcomes broadly in line with NICE Guidance for those who engaged with treatment (52% recover). Employment benefits. Maintenance of gains.
- When compared with GP referrals, self- referrals were as severe, tended to have had their anxiety disorder or depression for longer, and had BME rates that were more representative of the community. Ditto social phobia & PTSD.
- Outcome does not differ by ethnic status or referral route
  - White 50%
  - Black 54%
  - Asian 67%

Why getting complete data matters.

(Clark, Layard, Smithies, Richards, Suckling & Wright, 2009, BRAT)



The National Plan

- A 6 year plan. First 3 years (2008-2011) funded in 2007 CSR (£300 million above baseline). Next 4 years (2011-2015) funded last month (£400 million)
- Train *at least* 6,000 new therapists in 6 years and employ them in new clinical services for depression & anxiety disorders. Initial focus on CBT.
- NICE Guidelines (including stepped care).
- National Curricula (high and low intensity practitioners: PWPs)
- Published set of competencies for all therapies (Roth, Pilling et al)
- Success to be judged by clinical outcomes (50% recovery target)
- Self-referral & Session by session outcomes measurement

What has been achieved so far?

Midway through Year 3

- IAPT services established in 95% of PCTs (BUT variation in service size means population coverage will be only 60%).
- Over 3,660 new High intensity therapists and PWPs have been appointed and will have completed their training by end of year.
- Currently seeing 310,000 per annum. Aim for 900,000 by 2015
- End of year two data shows programme is on target
  - 399,460 people seen in services (target 400,000)
  - 13,962 moved off sick pay & benefits (target 11,100)
  - 40% recovery rate

Year One Data Review

- 32 Year One sites provided a full data download (137,285 patients).
- Period covered: 1st Oct 08 to 30th Sept 09.
- Initial report now available at: www.iapt.nhs.uk

Equity of Access: Data Completeness

Gender	97%
Age	96%
Referral Source	98%
Ethnicity	69%
Provisional Diagnosis	55%

Equity of Access

Gender

- As expected.
- Female (66%) Male (34%). (*APMS 61% vs 39%)*

Age

- Lower than expected people from over 65.
- 18-34 age (39%), 35-64 (56%), 65+ (4% vs *APMS 12%)*

Ethnicity

- Under-representation of people from BME communities (12%) against local profiles.

Referral Source

- GP referrals (85%) Self referrals (10%). Minimal referrals from other services. *Newham had 21% self-referral*

Equity of Access by Disorder

- Overrepresentation of patients with Depression (29%) or Mixed Anxiety and Depression (29%) compared to prevalence rates

- Under-representation of patients with persistent anxiety disorders including: PTSD, OCD, Panic Disorder, Social Phobia, Agoraphobia (8.5% total).

What level of treatments did people receive?

Low intensity only	38% of patients
High intensity only	28% of patients
Low & High intensity	17% of patients
Step up rate (approx)	*30%*
Other treatment	8% (e.g employment support)

Compliant with NICE Guidance?

YES broadly. PTSD has lowest rate of Low intensity intervention (14%) and highest rate of High (72%). Within High intensity interventions the pattern of CBT vs counselling is largely compliant.

Disorder	***CBT***	***Counselling***
Depression	19%	19%
Recurrent Depression	34%	12%
Social Phobia	51%	3%
Specific Phobia	52%	3%
Agoraphobia	50%	3%
OCD	64%	3%
PTSD	55%	14%
GAD	24%	16%

Low Intensity Treatments Provided

Guided Self-Help	26 %
Pure Self-Help	24 %
Psychoeducation Groups	9 %
Behavioural Activation	7 %
CCBT	6 %
Structured Exercise	3 %

Results: clinical outcomes

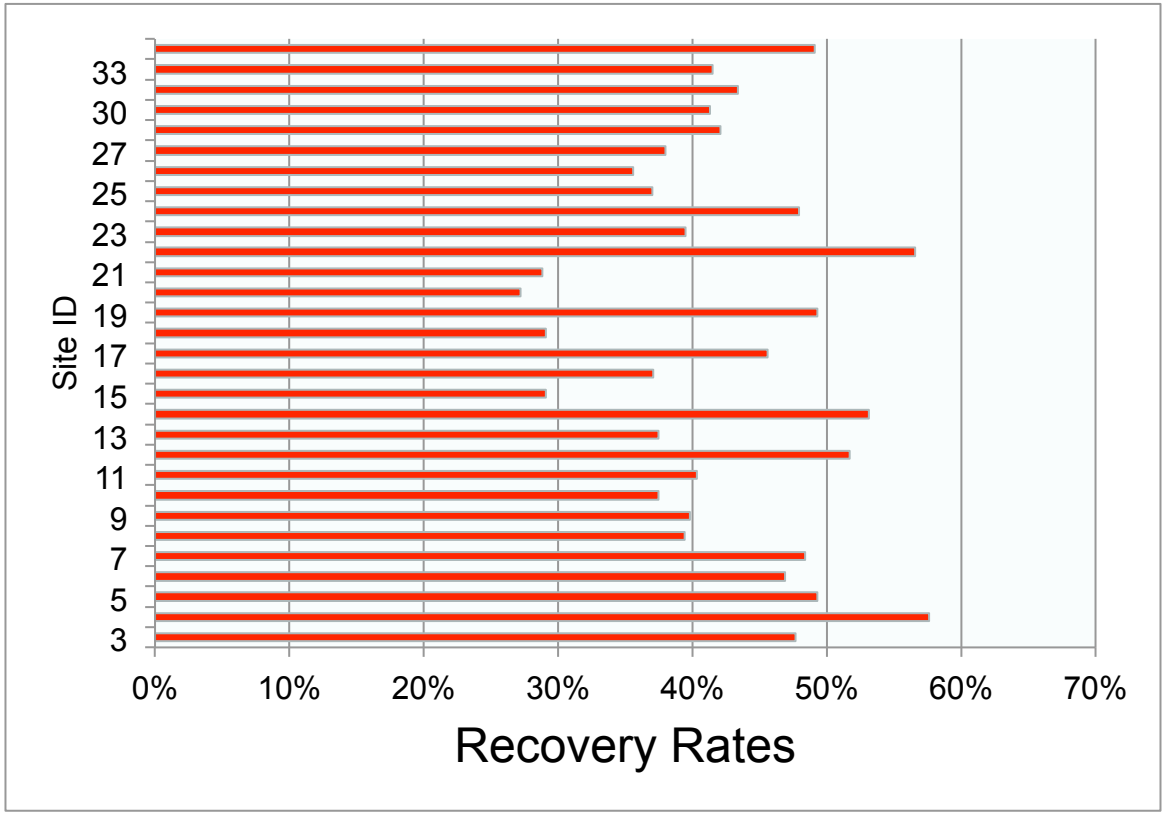
- 92% of patients who had at least two sessions had pre and post/last available depression (PHQ) and anxiety (GAD) scores.

- Recovery rates using PHQ9 and GAD7 – 42%

Variability in Recovery Rates

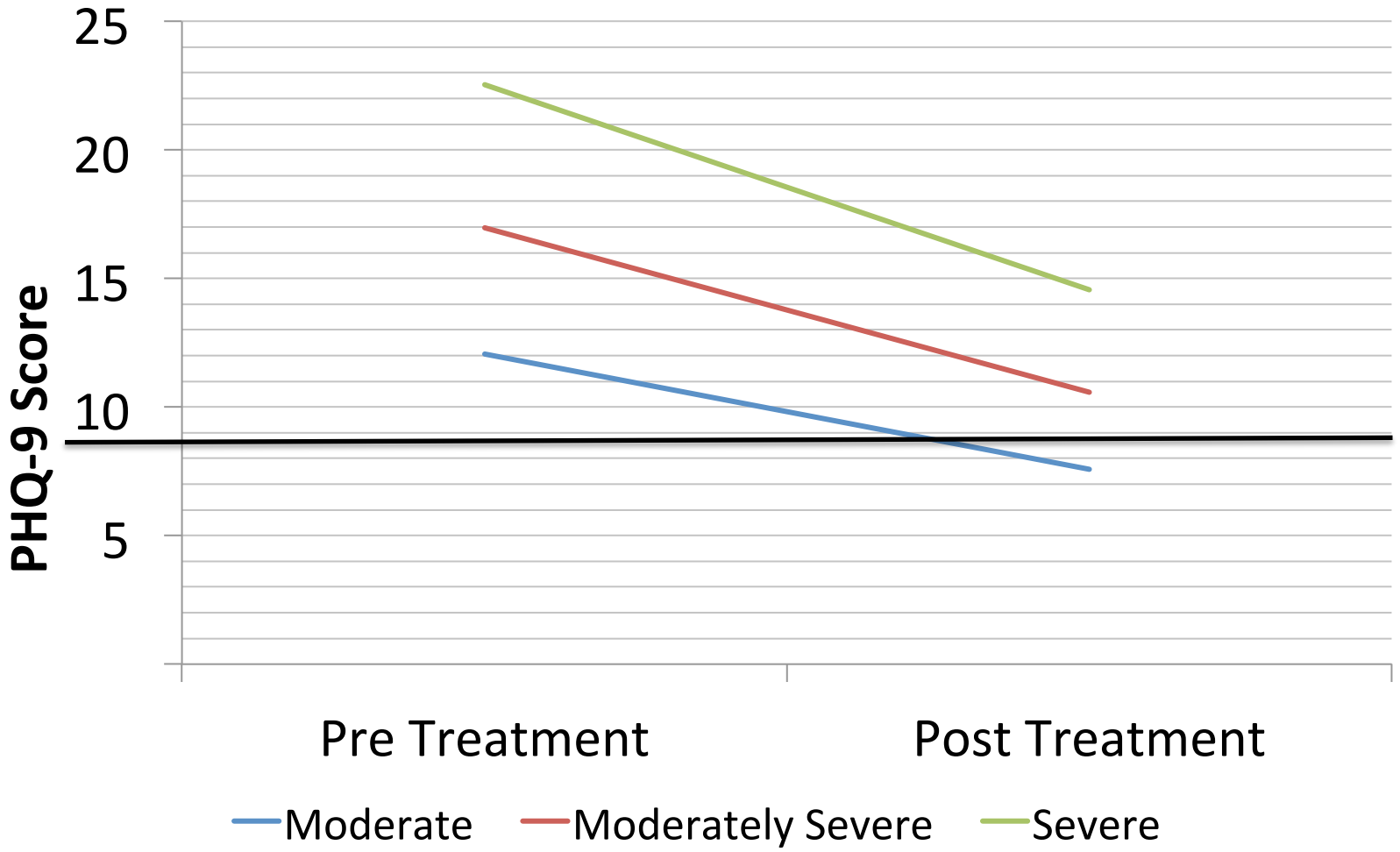
Gyani, Shafran, Layard & Clark (2011)

- Site recovery rates in the first year of IAPT ranged from 27% to 58%



The Effect of Severity on Recovery

- The greater initial PHQ-9 and GAD-7 scores were, the less likely patients were to meet criteria for recovery
- But the greater the actual change



Effect of severity on treatment received

- Patients with higher initial PHQ-9 and GAD-7 scores received more sessions of treatment

- Patients with higher initial PHQ-(and GAD-7 were more likely to have low & high intensity therapy or high intensity only

Self Referral

- Sites with a higher proportion of self-referred patients had higher recovery rates
- Self referred patients had similar PHQ-9 and GAD-7 scores to GP referrals, but slightly higher WSAS scores
- Self referred patients recovered in significantly fewer sessions

Stepped Care

The greater the proportion of patients stepped up at a site, the more likely:

- patients at the site recovered

- unemployed patients at the site gained employment

- If all patients who did not recover after low intensity therapy were stepped up, recovery rates would have increased from 42% to between 48%- 54%

Importance of NICE compliance

- Most patients received NICE compliant treatment
- However, a substantial number of patients with GAD received counselling, which is not recommended by NICE and a substantial number of patients who had low intensity interventions had pure self-help, rather than guided self-help

- Recovery rates suggest deviation from NICE was detrimental:

For Depression	CBT = Counselling
For GAD recovery	CBT > Counselling
For MADD recovery	CBT > Counselling
For Recovery at LI	Guided Self-Help >Pure Self-Help

Summary of Evaluations
(Gyani,Shafran, Layard & Clark 2011)

- Findings generally support the IAPT model
- PWP and Hi therapists are equally valuable and services do best if they deploy both (plus employment advisors) in a functional stepped care system
- Initial symptom scores influenced the amount and type of treatment patients received (✔NICE) and their outcome
- Compliance with NICE treatment recommendations was associated with better outcomes
- Sites that offered a greater number of sessions had better outcomes

Summary of Evaluations (continued)

- Session by session outcome monitoring essential
- A core of experienced, fully trained clinicians to provide supervision AND treat patients is essential
- Self referral is important for equity

The Coalition: our programme for government

25. PUBLIC HEALTH

The Government believes that we need action to promote public health, and encourage behaviour change to help people live healthier lives. We need an ambitious strategy to prevent ill-health which harnesses innovative techniques to help people take responsibility for their own health.

- We will give local communities greater control over public health budgets with payment by the outcomes they achieve in improving the health of local residents.
- We will give GPs greater incentives to tackle public health problems.
- We will investigate ways of improving access to preventative healthcare for those in disadvantaged areas to help tackle health inequalities.
- We will ensure greater access to talking therapies to reduce long-term costs for the NHS.

Key Policy Documents for Future of IAPT (available at www.iapt.nhs.uk)

- *Operating Framework for the NHS in England 2011/12*

- *No Health without Mental Health*
  - *Talking Therapies: Four Year Action Plan*

    (£400m investment leading to £700m public sector savings in healthcare, tax and welfare)
  - *ISB data standard (equity of access, data completeness, symptom, disability and employment/benefit outcomes*

Details of Four Year Action Plan

- To complete the role out of IAPT services by training and employing a more CBT therapists (2,400) in next 3 years, continuing the other therapies CPD programme, and extending employment support

- Aim for average size (250,000 population) and average deprivation PCT area to have service with *at least* 40 wte clinicians plus employment advisors and support staff.

- To start to develop a children's IAPT programme

- To extend IAPT services to people with long-term physical health problems and medically unexplained symptoms

- Severe & Enduring Mental Health Problems

Which Psychological Treatments are recommended by NICE?

Problem	**NICE Recommended Treatments**
Anxiety Disorders (all six)	CBT only
Depression (moderate-severe)	CBT or IPT (with meds)
Depression (mild-moderate)	Low intensity CBT based interventions CBT (including group) Behavioural Activation IPT Behavioural Couples Therapy *If patient declines above, consider:* Counselling Short-term psychodynamic treatment

Extending patient choice in the treatment of depression

- Continuing professional development for existing workforce
- DH has published competencies for IPT, counselling, brief dynamic therapy, and behavioural couples therapy.
- Training programmes comprising 5 days of workshops followed by case supervision.

Research Questions about widening the range of therapies

How to make informed choice possible?

How many more people will recover?

- Are the people who respond to one psychological treatment the same as those who respond to others?

- Importance of treatment credibility

- Hollon's recent meta-analysis (JCCP in press)

  ES against control condition (placebo)

  low severity depression d = 0.22

  high severity depression d = 0.63

Public Transparency

Currently

- IAPT services submit to government 3 months data on number of people seen and average recovery rates for the service.

From April 2012

- IAPT services *required* to submit 50 data items *per patient* covering demographics, diagnosis, type of treatment and pre & post treatment scores.
- Central processing
- Reports for local services
- Public access to be determined

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Thank You