Improving Access to Psychological Therapies & Employment Support in England

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The scale: mental health problems are common

1 in 6 adults has a mental health problem at any given time.

Source: APMS 2007

There is little evidence that prevalence rates are increasing generally.

Source: Spiers et al (2011)

Mental ill-health is estimated to cost government £18-21bn a year.

Source: internal estimates based on Black, C (2008)

Distribution of sickness benefit claimants by main health condition, 1995-2012

- Other conditions
- Mental and behavioural
- Musculoskeletal

Source: DWP admin data. Figures cover ESA, IB and SDA claimants combined.
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.
## Which Psychological Treatments are recommended by NICE?

<table>
<thead>
<tr>
<th>Problem</th>
<th>NICE Recommended Treatments</th>
</tr>
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<tbody>
<tr>
<td>Anxiety Disorders (all six)</td>
<td>CBT only</td>
</tr>
<tr>
<td>Depression (moderate-severe)</td>
<td>CBT or IPT (with meds)</td>
</tr>
<tr>
<td>Depression (mild-moderate)</td>
<td>Low intensity CBT based interventions, CBT (including group), Behavioural Activation, IPT, Behavioural Couples Therapy</td>
</tr>
<tr>
<td></td>
<td><em>If patient declines above, consider:</em></td>
</tr>
<tr>
<td></td>
<td>Counselling, Short-term psychodynamic treatment</td>
</tr>
</tbody>
</table>
People with mental health conditions tend to have low employment and high inactivity rates

- The employment deficit is largest (23%) for people with mental health conditions (Berthoud, 2011)*
- But evidence suggests that paid employment is generally beneficial, if the work is safe and accommodating for the mental health condition (Waddell and Burton, 2006)

<table>
<thead>
<tr>
<th>Employment rates for selected groups</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health problems</td>
<td>14.2%</td>
</tr>
<tr>
<td>Musculoskeletal conditions</td>
<td>60.4%</td>
</tr>
<tr>
<td>All disabled people</td>
<td>46.9%</td>
</tr>
<tr>
<td>Total (general population)</td>
<td>71.6%</td>
</tr>
</tbody>
</table>

*The employment deficit is the difference in employment rate between disabled people and comparable non-disabled people

People with mental health problems fare worse in employment at a group level, but this is not the case for all individuals
The challenge: mental health affects much of Department of Work & Pension’s work

Proportions and approximate numbers of working age adults with mental health conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>General population</th>
<th>Jobseeker’s Allowance claimants</th>
<th>Sickness benefit claimants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health problems</td>
<td>18%</td>
<td>23%</td>
<td>43%</td>
</tr>
<tr>
<td>Musculoskeletal conditions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All DDA disabled people</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (general population)</td>
<td></td>
<td></td>
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</tbody>
</table>

Employment rates for selected groups

- Mental health problems: 34.8%
- Musculoskeletal conditions: 60.4%
- All DDA disabled people: 46.9%
- Total (general population): 71.6%

Source: LFS. In house analysis of year to Sept 2012

People with mental health problems fare worse in employment at a group level, but this is not the case for all individuals.

Sources: General population, APMS 2007; Jobseeker’s Allowance claimants, National study of work-search and wellbeing and Labour Force Survey; Sickness benefit claimants, DWP admin data.
## The Original Economic Case

Layard, Clark, Knapp & Mayraz (2007)

<table>
<thead>
<tr>
<th>Cost (per patient)</th>
<th>750</th>
</tr>
</thead>
</table>

### Benefits to Society

- *Extra output* 1,100
- *Medical costs saved* 300
- *Extra QALYs* 3,300
- Total 4,700

### Benefits to Exchequer

- *Benefits & taxes* 900
- *Healthcare utilisation reductions* 300
- Total 1,200
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.
- 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%
The National Programme

• First 3 years (2008-2011) funded in 2007 CSR (£300 million above baseline).

• Train at least 6,000 new therapists and employ them in new clinical services for depression & anxiety disorders. Initial focus on CBT. Now being expanded to other NICE approved therapies

• Services follow NICE Guidelines (including stepped care).

• National Training Curricula (high and low intensity practitioners: PWP's)

• Published set of competencies for all therapies (Roth, Pilling et al)

• Success to be judged by clinical outcomes (50% recovery target, with many others showing some benefit)

• Self-referral & Session by session outcomes measurement
Talking Therapies: four – year plan of action (2011-15) funded in 2011 (£400m)

- Complete roll-out of services for adults
- Improve access to psychological therapies for people with Psychosis, Bipolar Disorder, Personality Disorder
- Initiate stand – alone programme for children and young people
- Improve access for older people and BME communities
- Develop models of care for:
  - Long Term Conditions
  - Medically Unexplained Symptoms
Start Point & Planning Assumptions

900k present to services
6m in need
600k complete treatment

300k Recover
(25k Move off Benefits)
Currently

• IAPT services established in 100% of health areas (PCTs/CCGs)

• Approx 4,000 new High intensity therapists and PWPs trained.

• At March 2012 programme is on target
  – 1.1 million people seen in services
  – 45,000 moved off sick pay & benefits (target 22,147)
  – 41% recovery rate

• Current access rate pa 600,000 & recovery rate 46%

• Initiation of a major CAMHS transformation using IAPT quality markers
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
• Compliance with NICE treatment recommendations was associated with better outcomes
• Sites that offered a greater number of sessions had better outcomes
• Session by session outcome monitoring is essential
• A core of experienced, fully trained clinicians to provide supervision AND treat patients is essential
Current KPIs

Based on aggregate data submitted to Information Centre by service commissioners every 3 months

- Local prevalence anxiety & depression
- Number of referrals to local IAPT service
- Proportion referrals entering treatment
- Number of active referrals waiting >28 days for 1st session
- % of local prevalence entering treatment
- Number who have completed treatment (2 or more sessions) in period
- % of initial cases who have completed treatment and recovered
- Number of people moving off sick pay or benefits
Recovery Performance to Q3 12/13
Performance to Q3 12/13

People moving off sick pay and benefits (Quarterly)

Waited More than 28 Days (Quarterly)
Summary

- High levels of awareness of economic and social cost of unemployment
- Integrated approach to addressing the particular impact of mental health
- IAPT is a clear example of policy in practice

BUT
Summary

• Policy alignment not as good as it could be
• Organisational incentives could be better
• Lack of consistent use of evidence based interventions
• Data deficiencies