NHS
Improving Quality

Improving Access to Psychological Therapies & Employment Support in England

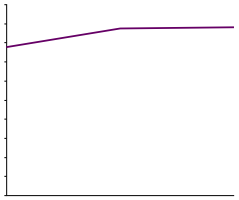
Kevin Mullins

Programme Director

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)

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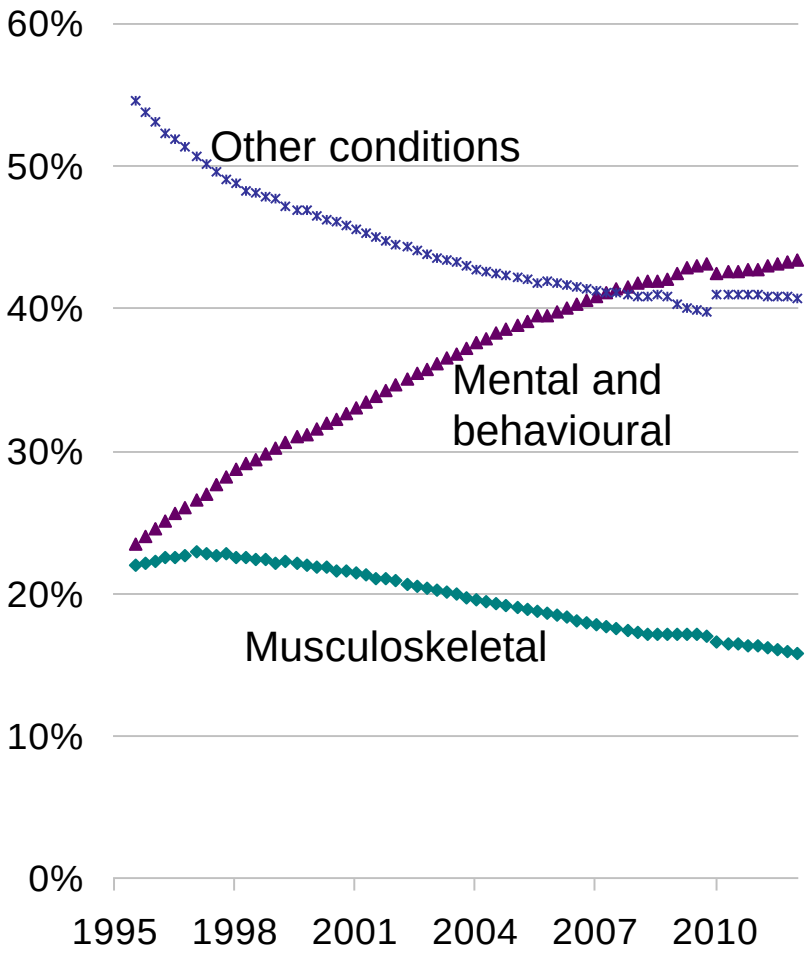
Mental ill-health is estimated to cost government **£18-21bn** a year

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

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



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?

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

People with mental health conditions tend to have low employment and high inactivity rates

Employment rates for selected groups	
Mental health problems	14.2%
Musculoskeletal conditions	60.4%
All disabled people	46.9%
Total (general population)	71.6%

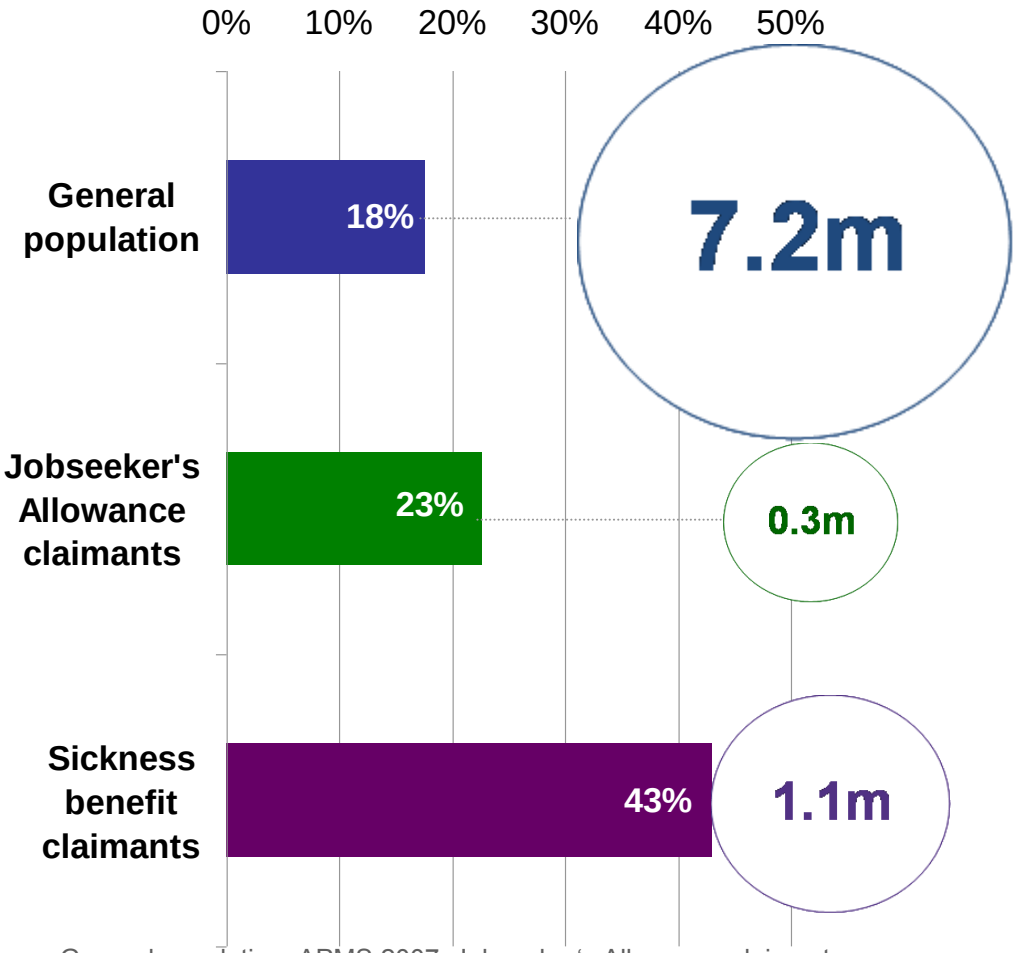
- The employment deficit is largest (23%) for people with mental health conditions (Berthoud, 2011)*
- But evidence suggests that paid employment is generally beneficial, if the work is safe and accommodating for the mental health condition (Waddell and Burton, 2006)

*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



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.

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**

The Original Economic Case

Layard, Clark, Knapp & Mayraz (2007)
National Institute Economic Review, *202*, 1-9.

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*
• *Healthcare utilisation reductions*	*300*
• Total	1,200

Demonstration Sites: First Year Results

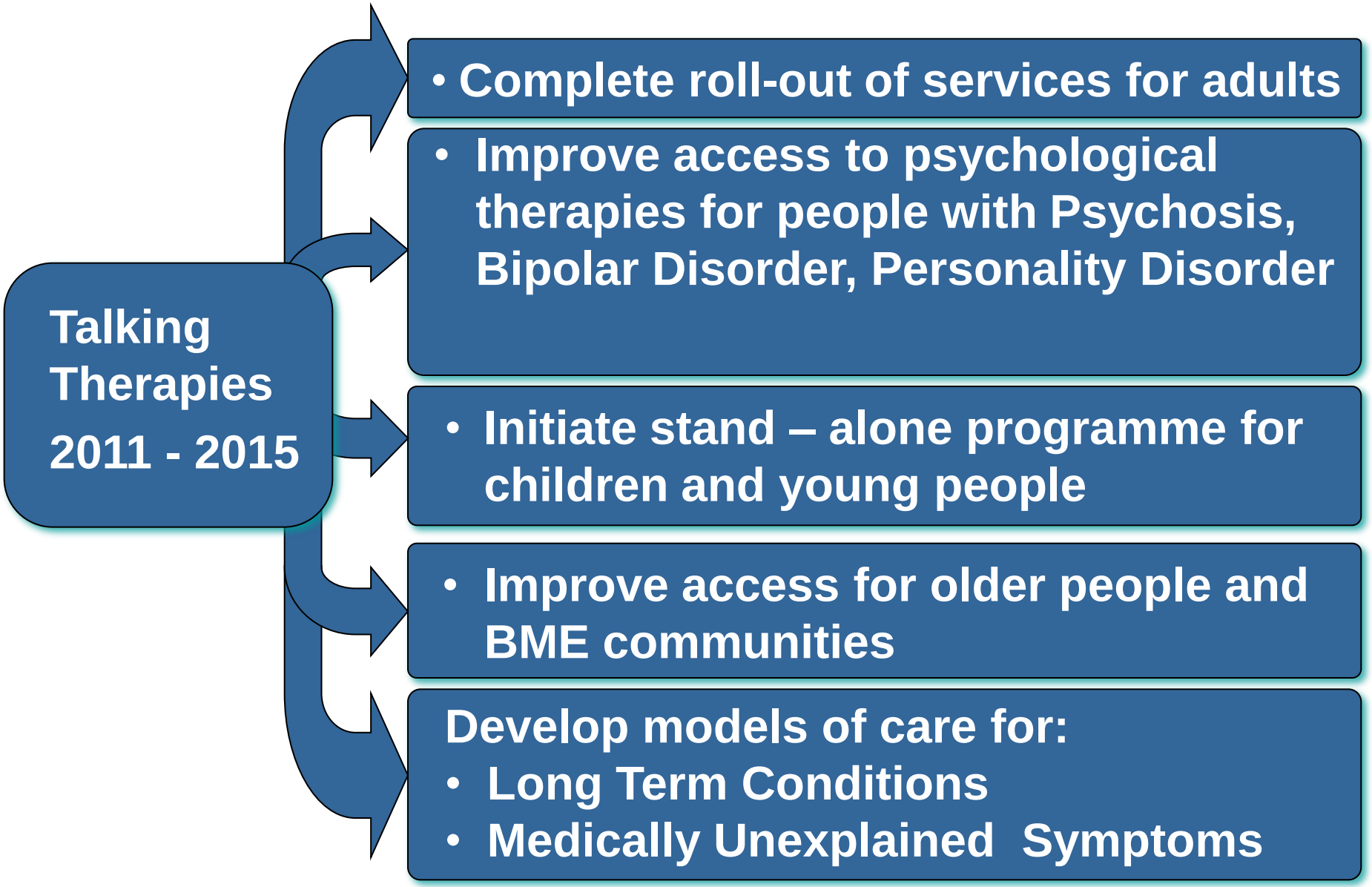
(see Clark, Layard,Smithies, Richards et al. (2009) *Behav. Res & Ther*)

- Excellent data completeness (99% in Doncaster, 88% Newham).
- Large numbers treated (approx 3,500 in first year). Use of Low intensity important.
- 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%

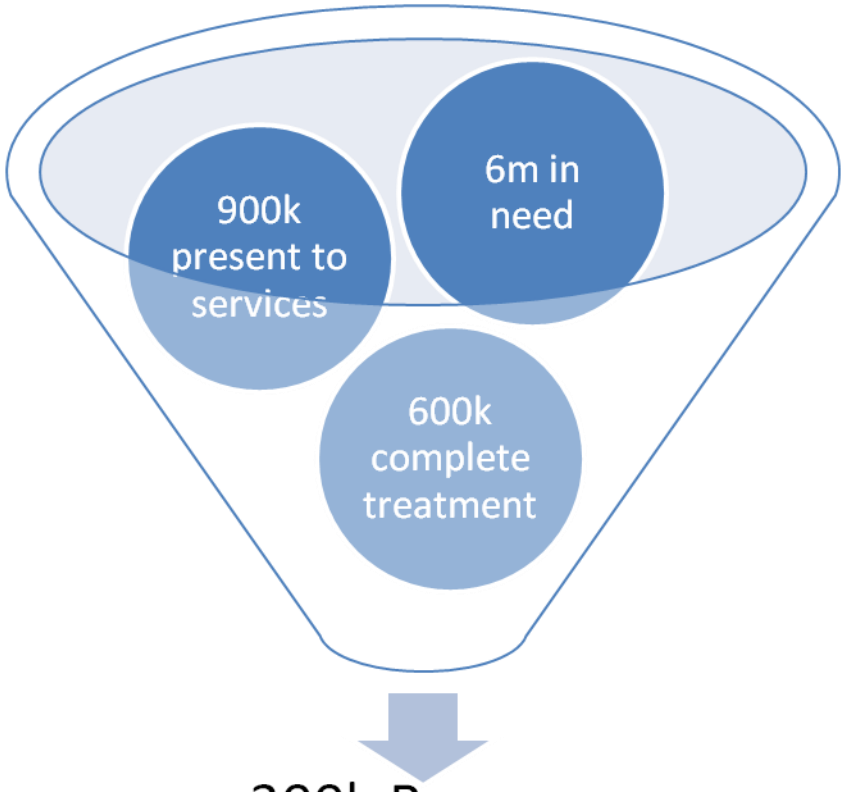
The National Programme

- 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: PWPs)
- 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)



Start Point & Planning Assumptions



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
  - 1.1million 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)

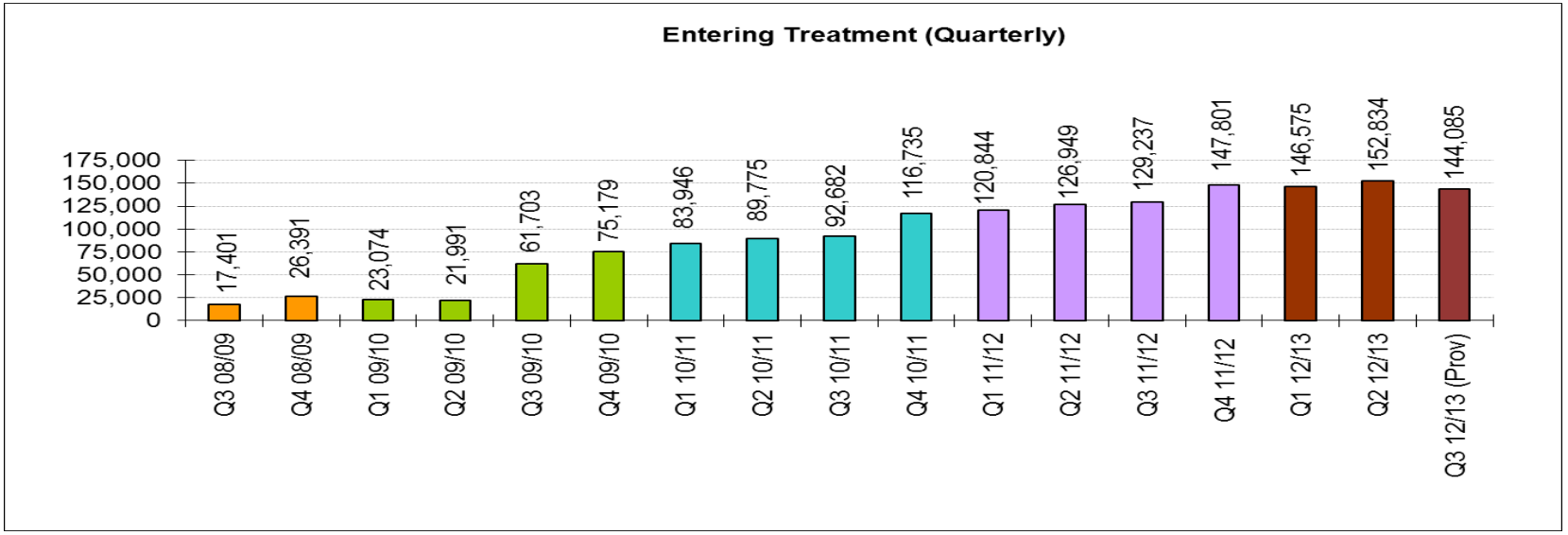
- Findings generally support the IAPT model
- PWP and Hi therapists are equally valuable and services do best if they deploy both (plus employment advisors) in a functional stepped care system
- Compliance with NICE treatment recommendations was associated with better outcomes
- Sites that offered a 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

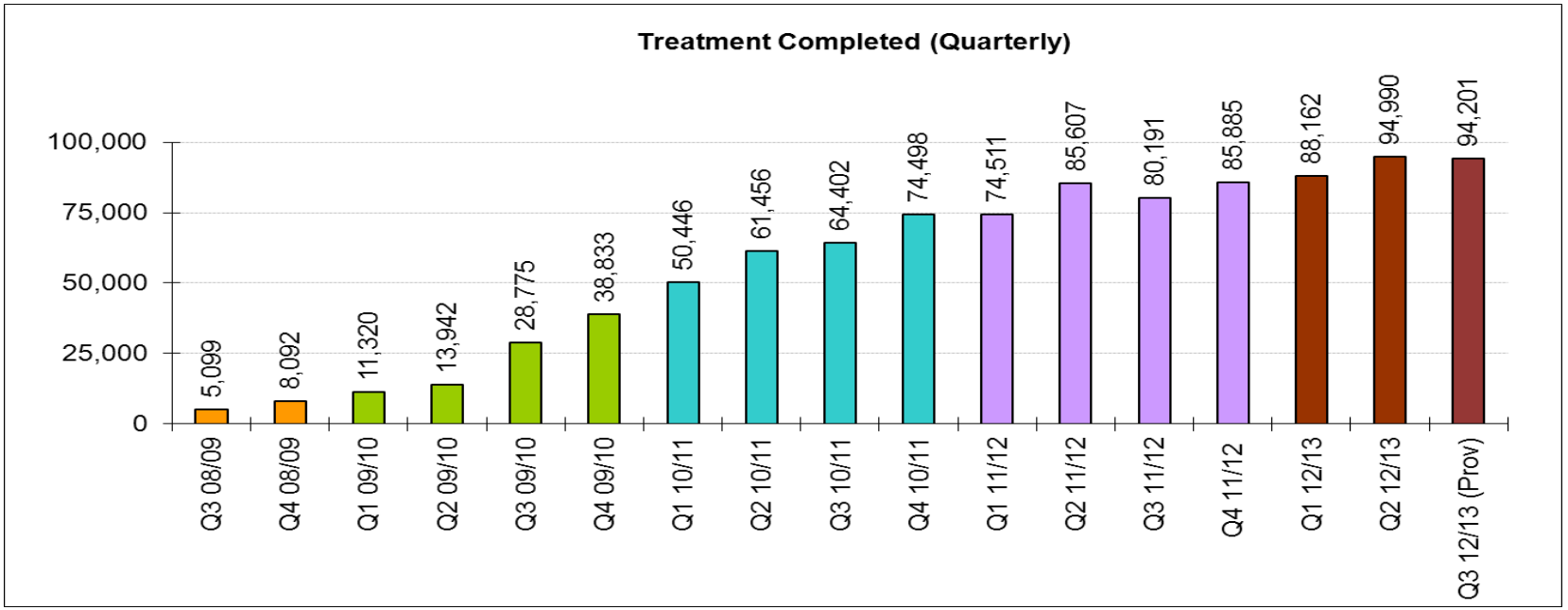
Current KPIs

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

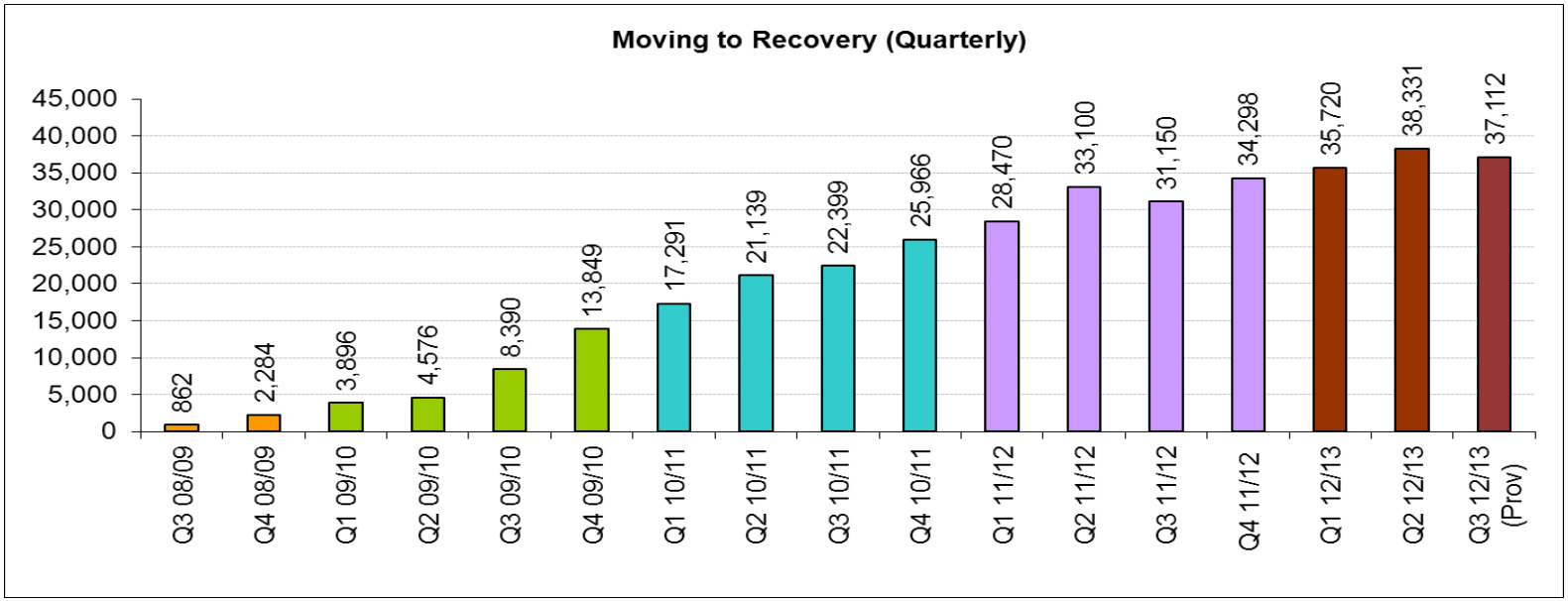
- Local prevalence anxiety & depression
- Number of referrals to local IAPT service
- Proportion referrals entering treatment
- Number of active referrals waiting >28 days for 1st session
- % of local prevalence entering treatment
- Number who have completed treatment (2 or more sessions) in period
-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

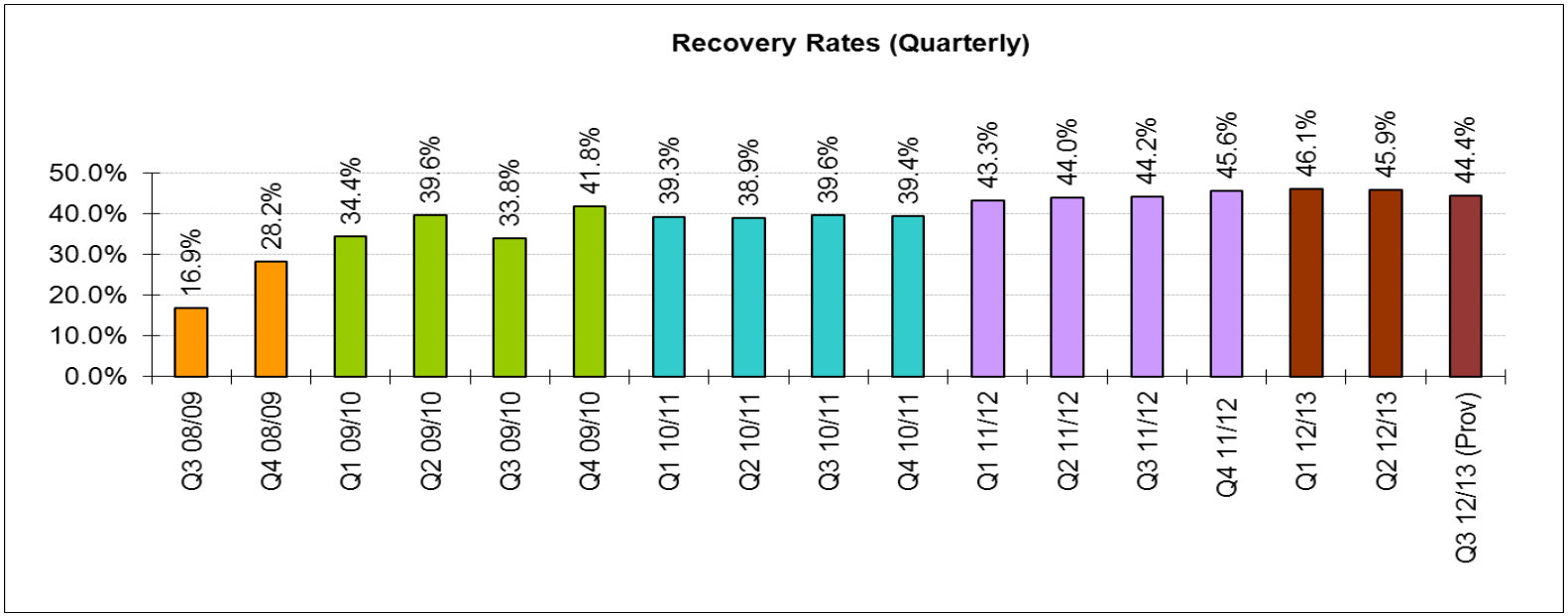
Access Performance to Q3 12/13



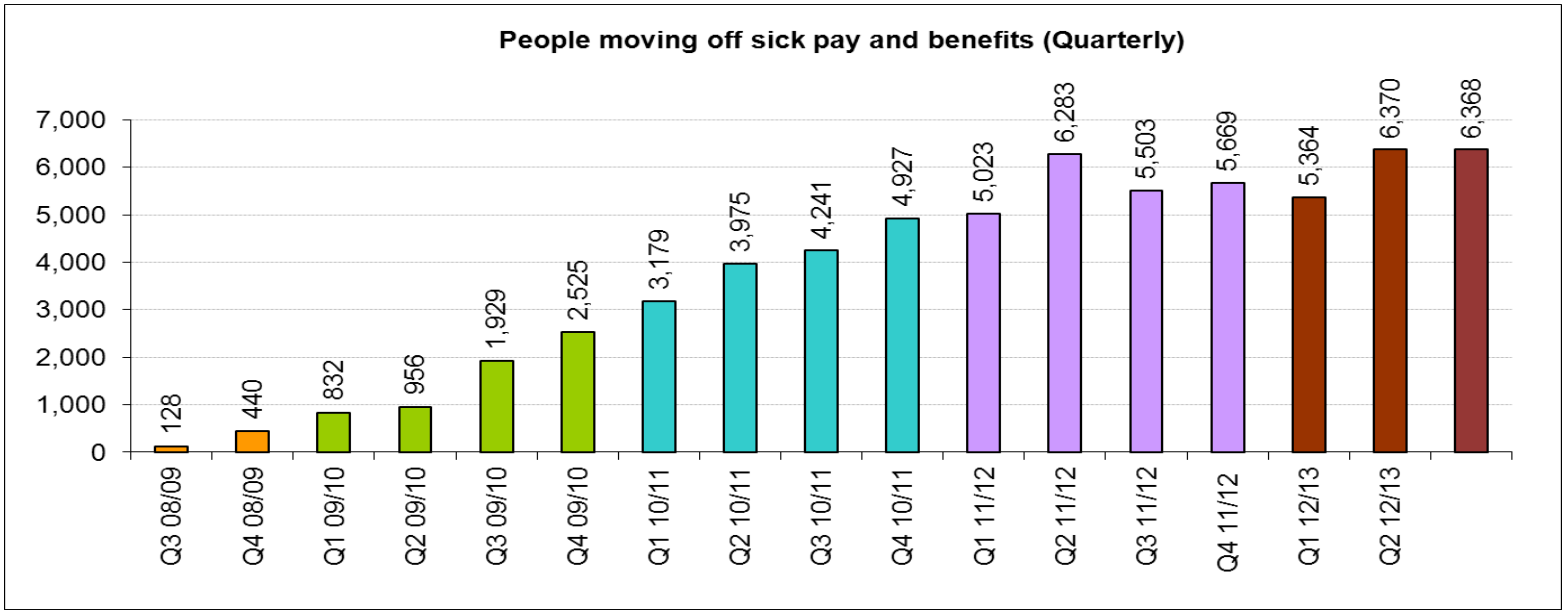


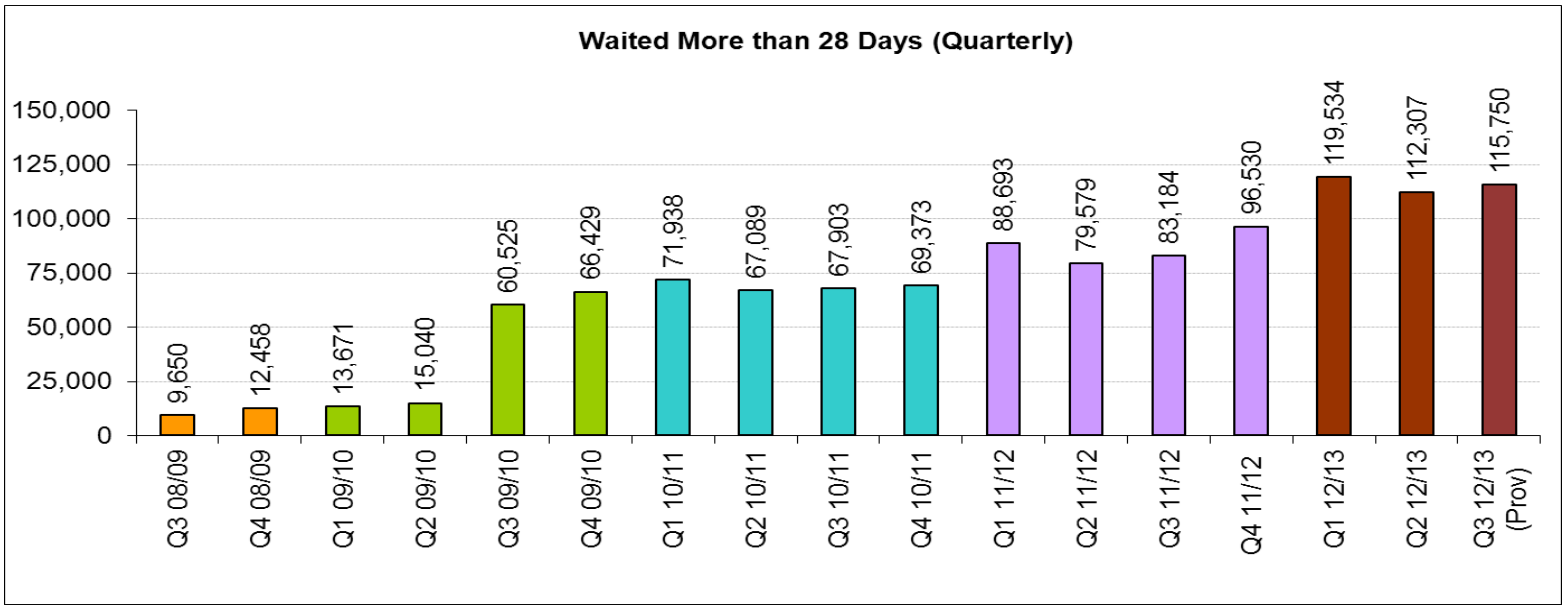
Recovery Performance to Q3 12/13





Performance to Q3 12/13





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