Improving Access to Psychological Therapies and care pathways for depression in the UK

Psychotherapy in Europe: Disease management strategies for depression.

Berlin, 23 February 2011
Psychotherapies in the UK

- National Health Service (NHS) funded by national taxation provides majority of mental health care
- Health care in Scotland, Wales and Northern Ireland is devolved
Psychological therapies in the UK

- NHS psychological therapies are delivered by
  - Clinical psychologists
  - Psychiatrists
  - Mental health nurse therapists
  - Counsellors
  - Other therapists with specialist training

- Where are they delivered?
  - family doctors’ surgeries, community mental health teams, inpatient and day hospital settings
  - and through specialist psychotherapy teams.
Private and ‘third sector’

• Psychotherapists also offer private services on a fee-for-payment basis
• Some are reimbursable by private insurance companies (many doctors and psychologists)
• Many ‘lay’ therapists operate privately; proposal to bring them into statutory regulation through the Health Professions Council
• Also a ‘third sector’ of voluntary and ‘not for profit’ organisations e.g. couples and bereavement counselling, suicide telephone helplines
NHS policy on psychotherapy: A Long Journey

• Dept of Health: no policy until 1996
• 1996 Strategic Policy Review
• 1999 National Service Framework for mental health included psychological therapies (PT)
• 2001 Dept of Health guideline on Psychological Therapies

• 2002 Mental health service mapping exercise includes PT
• 2003 Primary care graduate mental health workers
• 2004 Guidance to the NHS on “Organising & Delivering Psychological Therapies”;
• 2004 “Choice consultation”: PT high priority for service users; poor availability a major source of dissatisfaction
• 2004 “NSF Five Years On” reinforced importance of PT & announced a national programme of work.
Step change in policy profile...

- National Institute for Health and Clinical Excellence (NICE) Guidelines
- These include psychological therapies alongside medical treatments
  - Depression in adults
  - antenatal & postnatal mental health
  - anxiety disorders
  - eating disorders
  - obsessive compulsive disorder
  - self-harm
  - borderline personality disorder
  - anti-social personality disorder
  - chronic fatigue
- Plus a technology appraisal
  - computerised Cognitive Behaviour Therapy
NICE Guidelines on adult depression

• Based on evidence review from randomized controlled trials

• For mild to moderate depression, initial treatment should be low intensity,
  – guided self-help, group CBT, computerized CBT.

• For more persistent or more severe depression first line treatments
  – cognitive behaviour therapy (CBT), Interpersonal Therapy (IPT), behavioural couples therapy, behavioural activation.

• Second line treatments
  – counselling or short term psychodynamic psychotherapy.
Stepped care model

**Focus of the intervention**

**STEP 1:** All known and suspected presentations of depression

**STEP 2:** Persistent subthreshold depressive symptoms; mild to moderate depression

**STEP 3:** Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression

**STEP 4:** Severe and complex depression; risk to life; severe self-neglect

**Nature of the intervention**

**STEP 1:** Assessment, support, psychoeducation, active monitoring and referral for further assessment and interventions

**STEP 2:** Low-intensity psychological and psychosocial interventions, medication and referral for further assessment and interventions

**STEP 3:** Medication, high-intensity psychological interventions, combined treatments, collaborative care and referral for further assessment and interventions

**STEP 4:** Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multiprofessional and inpatient care
Principles and practice

• Two principles to stepped care
  – Should be at the lowest intensity consistent with effectiveness
  – Should be self-correcting: feedback system of review and ‘stepping up’ or ‘stepping down’

• Family doctors (General Practitioners) rewarded for monitoring depression using PHQ-9 and making appropriate referral

• Care pathways in practice are rather more chaotic and complex
Improving Access to Psychological Therapies (IAPT)

- Mental ill health reduces productivity and increases costs of welfare benefits (estimated at £8bn)
- CBT recommended in NICE guidance but very little available
- CBT as a cost effective way to ‘train people to be happy’ and moving people into economically productive employment
- Convinced Government to invest £170m (€200m) in new programme Improving Access to Psychological Therapies.

Professor Lord Richard Layard made the economic argument for investment in cognitive behaviour therapy.
Progress of IAPT

• Two pilot sites from 2006, shortly followed by further investment
  – Three year research evaluation recently completed by our group at University of Sheffield
• IAPT now being rolled out across England
• Does not apply to rest of UK (Scotland, Wales or Northern Ireland) but similar approaches being developed.
• Scope is expanding to include other non-CBT psychotherapies; counselling & brief psychodynamic therapy.
Evaluation of IAPT pilot sites: 30 second summary of results!

• Did it increase access?
  – Yes, faster access and greater coverage (1% to 6.3%)

• Was it clinically effective?
  – Yes, as effective as other therapies

• What did the patients think of it?
  – Liked fast access, many felt helped but less satisfaction with treatment length, & some found it impersonal.

• Did it get people back to work?
  – Reduced sickness absence, but little evidence of reducing unemployment or welfare benefits

• Was it cost effective?
  – Depends which measure you use! Between £20,000 (€23,620) to £37,000 (€43,690) per Quality Adjusted Life Year. (QALY)
Final thoughts...

Psychotherapy is moving from ‘cottage industry’ to industrial scale of delivery.

Psychological therapy as industrial process

- Requires standardised production in the public sector and a replicable process to reach a basic standard within minimum variation in quality.
- Professionals as technicians to deliver specific parts of the process and to drive down unit costs.
- Private sector less influenced by these imperatives.
Thank you for listening...

Danke für Ihre freundliche Aufmerksamkeit