Enforcing ill health is not all in the mind

Emma Stanton reviews the success of Improving Access to Psychological Therapies, a flagship programme to get people into mental health treatment.

The 2007 survey on adult psychiatric morbidity estimated that more than one-sixth of the UK population suffered from a common mental health disorder. The Improving Access to Psychological Therapies (IAPT) programme is a national initiative aimed at improving access to routine evidence-based treatments for people with common mental disorders such as anxiety and depression.

In his Depression Report, Professor Richard Layard of the London School of Economics outlined how comprehensive access to psychological therapies could produce significant direct benefits to patients’ mental health and indirect benefits to their physical health.

According to the report, the total cost to the economy, in terms of loss of output, was estimated to be £12bn, of which £7bn was borne by the taxpayer; the estimated cost of a psychological therapies service was £0.6bn.

Highest level

After two pilot services in Newham and Doncaster demonstrated impressive recovery rates (approximately 50 per cent of those treated) and a second phase of rollout to pathfinder sites, further waves of IAPT culminated in a Department of Health plan for a nationwide rollout backed by a £400m government investment for four years from April 2011.

As a flagship mental health initiative that has received attention at the highest level of government, IAPT is well funded and publicised. It is also a service that makes significant use of data with nationally set key performance indicators for performance management, benchmarking and to achieve the national IAPT programme objectives.

In 2012, Beacon UK, a mental healthcare provider, analysed the indicator data submitted by existing IAPT services across England for 2011-12 to benchmark current performance and identify arising challenges. Analysis revealed that:

- 533,550 people accessed IAPT services, reaching only 9 per cent of people with anxiety and depression disorders
- Four out of 31 (13 per cent) IAPT services in London and 37 out of 151 (25 per cent) services in England achieved the national target of a 50 per cent recovery rate
- 96,770 (11 per cent) people waited for more than 28 days from referral to their first treatment session
- 22,498 (7 per cent) people no longer required sick pay or benefits following a course of treatment
- 60 per cent of referrals to IAPT entered treatment; the highest acceptance rate was at Calderdale (99.7 per cent) and the lowest Telford and Wrekin (28.9 per cent).

We identified three challenges for commissioners and providers of IAPT services to achieve the national objectives.

Measuring the value of IAPT

Distinct funding and objectives have incentivised commissioners to consider IAPT as a separate and distinct entity rather than integrating it into the pre-existing healthcare economy. For example, the absence of a strong relationship with the local community mental health team risks people “falling through the cracks”.

The outcomes data is, however, not without flaws: IAPT services treating people who are severely ill may see greater improvement in their questionnaire scores than their actual recovery rates, for example. This is because overall scores are less likely to dip past the defined threshold for recovery.

Looking ahead, the definition of recovery in IAPT is likely to change to patients attaining a set level of improvement, defined by a questionnaire score rather than a service reaching a certain a threshold. Outcomes measurement for IAPT could be improved by risk adjustment to take into account local areas and individual patients’ needs. In addition, condition-specific measures and individual, patient-defined recovery indicators could be captured. Improved value may also be achieved by deploying services.
Defining the scope of IAPT

The initial goal for IAPT was to deliver short, targeted psychological interventions, as per National Institute for Health and Clinical Excellence guidelines for stepped care, focusing on low and high intensity interventions (see figure). A common challenge facing IAPT services, however, is the temptation to provide care to patients who are complex and outside of the defined scope of IAPT contracts.

As shown, Step 4 is intended for people with severe, complex mental health problems that require higher intensity care, or for those requiring multidisciplinary team input but not meeting the referral threshold for secondary mental health services. Such people require more specialist care than was intended to be provided by the standard IAPT model.

Some commissioners have developed innovative approaches to providing care for people with complex mental health problems, including:

- Contracting a distinct “Step 4 service” from the same provider, separately from IAPT
- Establishing a single point of access for a primary care-based federated model of mental health services, including IAPT, but extending it to include other providers
- Running an independent assessment and referral service providing a single point of contact for all IAPT and substance misuse issues alongside the main mental health providers. Providers are reimbursed according to the outcomes achieved.

Improving access to IAPT

By 2015, the national access rate for people with a common mental disorder is expected to be 15 per cent. According to the 2007 survey into adult psychiatric morbidity, common mental disorders have a higher prevalence in the North East (26 per cent of women and 11.6 per cent of men), while the lowest prevalence was in South Central (18.6 per cent of women and 8.4 per cent of men).

Overall, there was a higher prevalence of mental health problems in black and other ethnic groups than in white and South Asian groups. In addition, divorced people and those with lower household incomes were also more likely to suffer from common mental disorders.

To improve access rates for different high-risk groups, IAPT services need to be marketed differently. Self-referral appears a more equitable way to improve access for those who are unlikely to visit their GP, such as some ethnic minorities. Working with third sector organisations that help ethnic minority groups who have mental health problems to provide language-specific psychotherapy services may be another way to enhance access. Employing “star workers” could help target higher risk groups, including those whose houses have been repossessed. Health trainers are also a source of referral, delivering services through community centres close to patients’ homes reduces the stigma of accessing mental health services.

Isolated short psychological interventions via IAPT are an evidence-based approach for people with common mental disorders. While the short term focus for commissioners is to improve access and recovery rates in line with national targets by 2014-15, the long term strategy must be to better integrate IAPT services into the broader health and social care landscape. Integration is not captured by any national key performance targets at present.

Further scope for improved productivity lies in technological innovations, including mobile apps and secure email to facilitate patient–therapist communication.

Overall, the IAPT programme is likely to more than pay for itself by improving the wellbeing of its service users and benefiting the wider economy. Dr Emma Stanton is an NHS psychiatrist and CEO at Beacon UK.