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Improving Access to Psychological Therapies

NHS

Improving Access to Psychological Therapies (IAPT) Manual

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Why was IAPT started?

- NICE recommends evidence-based psychological therapies as first line interventions for depression and all the anixiety disorders

- Public prefers psychological therapies to medication in 3:1 ratio

- BUT in 2007 less than 5% of people received a NICE recommended psychological therapy

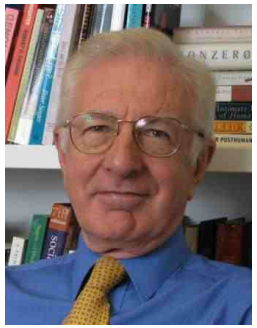
The IAPT Solution

Increase the availability of effective (NICE recommended) psychological treatments for depression and all anxiety disorders by:

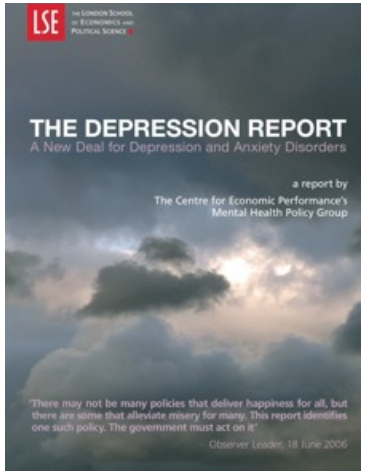
- training a large number of psychological therapists
- deploying them in specialized, local services for depression and anxiety disorders
- measuring and reporting clinical outcomes for ALL patients who receive a course of treatment (public transparency)

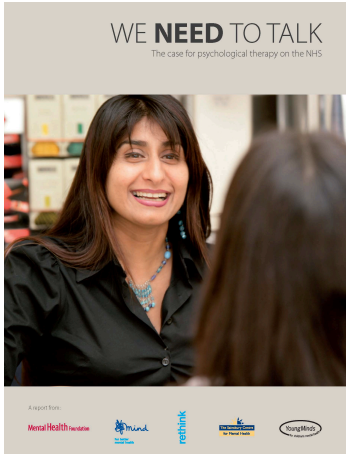
How did it come about?

NICE guideline



Omagh Bomb, Lobbying & Public Campaign



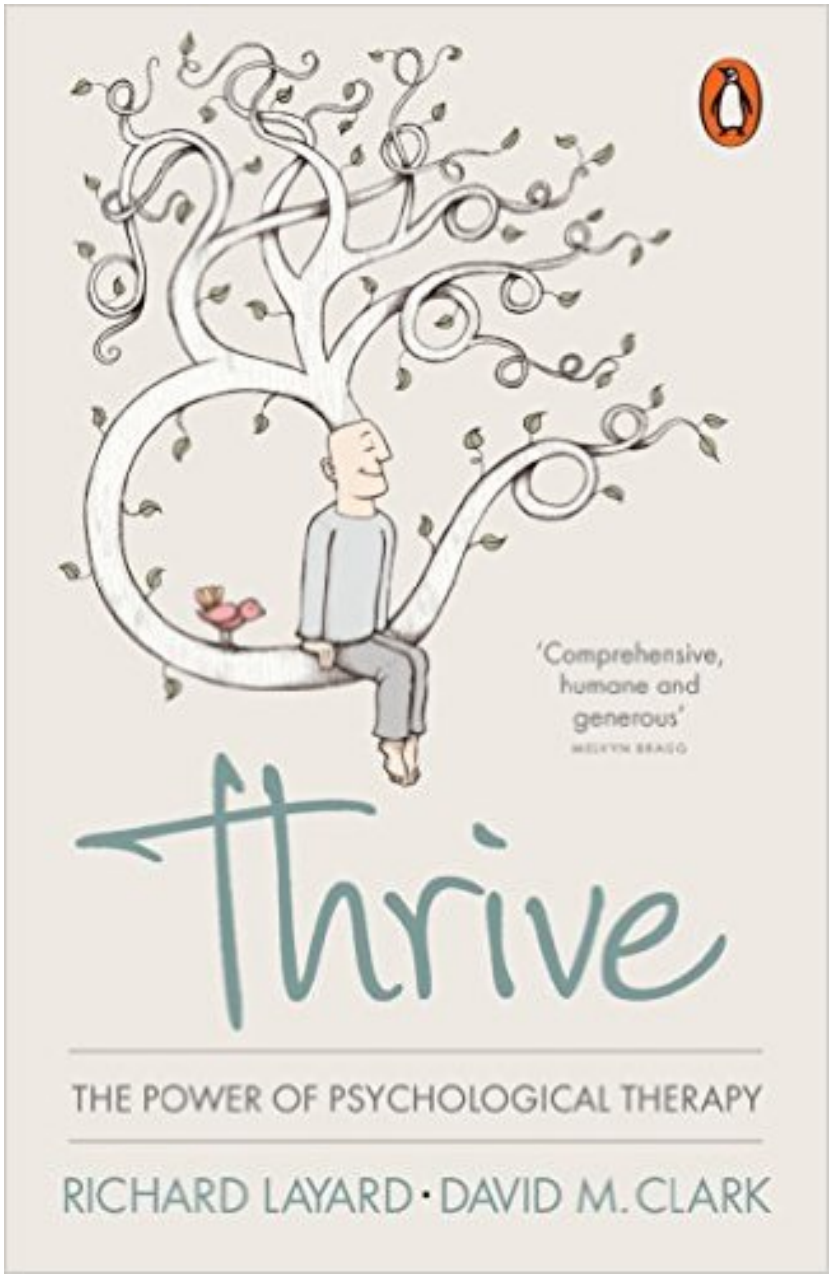


Political Support

Brown

Cameron & Clegg

May



WHY IAPT HAS ZERO NET COST

- Gross cost per person treated £650

- Savings on physical healthcare > £650
- Savings on benefits/taxes > £ 650

- *Actual cost per course of treatment £684*

IAPT So Far (2017)

- Transformed treatment of anxiety & depression
- Stepped care psychological therapy services established in every area of England. Self-referral.
- Approx 16% of local prevalence (950,000 per year) seen in services
- Around 60% have course of treatment (approx 575,000 per year)
- Outcomes recorded in 98% of cases (pre-IAPT 38%)

IAPT So Far (2017)

- Very strict double (depression & anxiety) recovery criteria

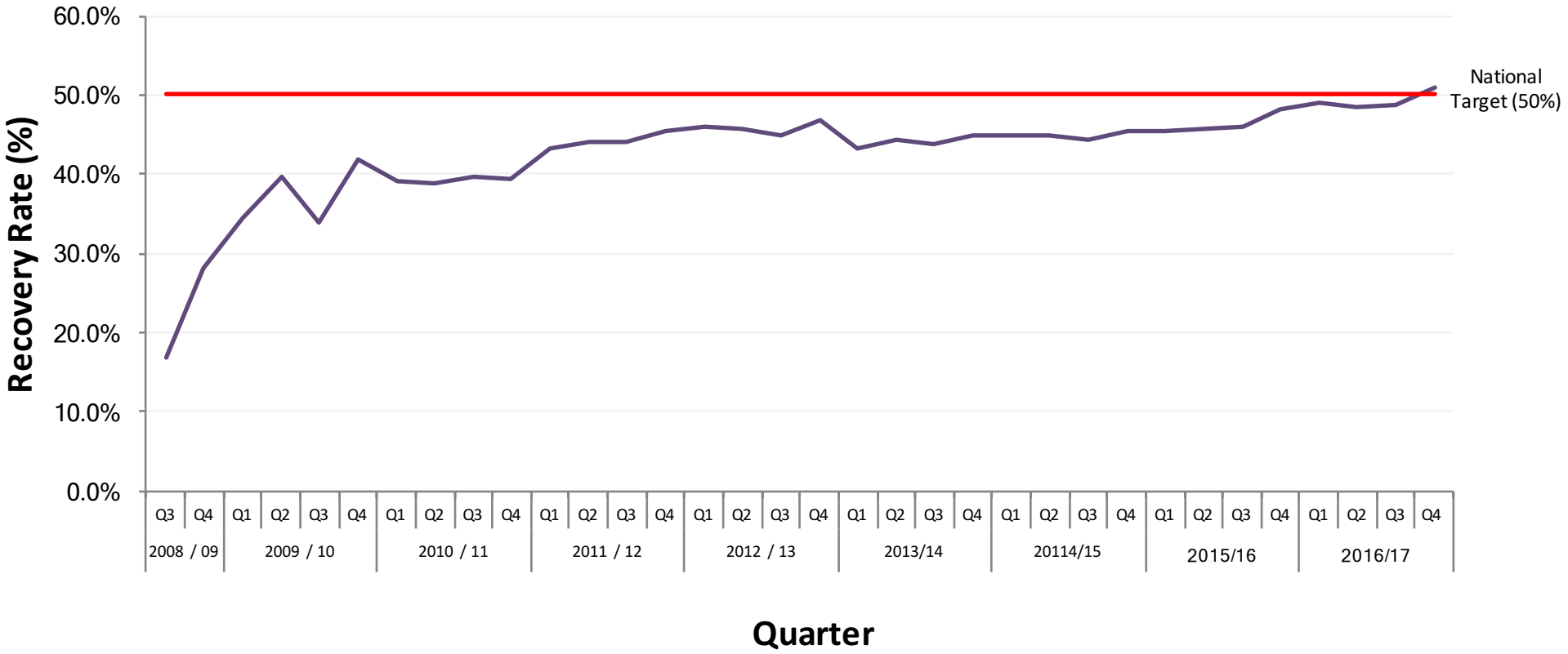
- Nationally 51% recover and further 16% improve *(Jan-May 2017).*

- Substantial Pre-Post Effect sizes

  – Depression (PHQ-9) ES = 1.4
  – Anxiety (GAD-7) ES = 1.5

- ***Overall results as good as research studies and in line with economic model***

IAPT national recovery rates



Expanding IAPT by 2021

- Increase numbers seen & treated by 66% (from 900,000 seen in 2015 to 1.5 million in 2021)
- Focus 2/3 of expansion on people with LTCs and/or MUS
- Increase use of digitally assisted therapies
- Expand workforce by 50-60%

Why focus on people with LTCs?

Fairness

- Currently under-represented. 21% of people treated in IAPT services but 40% of cases in the community.

Great prospects for patients and their families

- NHS Digital data shows outcomes as similar to people without LTCs (43% vs 46% recovery in 2015/16 LTC vs Non-LTC)

A moment in history

Why focus on people with LTCs?

Economic Sense for the NHS (Layard & Clark 2014, Ch 11)

- LTC healthcare costs are 50% higher in people with depression and/or anxiety disorders
- Psychological therapy reduces annual physical healthcare costs by average of 20% (meta-analysis of 91 studies)
- When data is available on cost of psychological treatment and physical healthcare saving in latter exceeds cost of former (26 of 28 studies)
- IAPT LTC wave 1 and Wave 2 sites are collecting further “on the ground” economic data

The IAPT Manual

- Replaces and updates multiple guidance documents issued between 2008 and the present
- A single authoritative source
- Web version can be continuously updated
- Captures key learning from progressive role out of the programme.
- Commissioned by NHS England. Developed with National Collaborating Centre for Mental Health

Previous Guides

IAPT Implementation Plan: National guidelines for regional delivery (Feb 2008)

IAPT Supervision Guidance

IAPT Commissioning Toolkit (April 2008)

Realising the Benefits: IAPT at Full Roll-Out (February 2010)

The Operating Framework for the NHS in England 2011/12

No Health without Mental Health (February 2010)

Talking Therapies: a Four Year Plan (February 2010)

Commissioning Talking Therapies for 2011/12 (March 2011)

IAPT Data Handbook 2

The IAPT Manual Chapters (1)

Main Guide

1. Introduction
2. Conditions treated by IAPT
3. Importance of delivering evidence-based care
4. The Workforce
5. Delivering effective assessment and treatment
6. Importance of data: monitoring outcomes & activity
7. Getting better results: Improving access
8. Getting better results: Reducing waiting times
9. Getting better results: Improving recovery

The IAPT Manual Chapters (2)

Main Guide

10. Getting better results: improving equity of access and outcomes for all
11. Working with the wider system
12. Key features of a well-commissioned IAPT service

The IAPT Manual Chapters (3)

Appendices & Helpful Resources

- Competence frameworks for IAPT therapies
- IAPT screening prompts for assessment interview
- Clinical cut-offs and reliable change
- Examples of Patient Tracking Lists (PTLs)
- Positive Practice Examples
- Case identification tools (screening questionnaires)
- Outcome Questionnaires
- Patient Experience Questionnaire
- Helpful web-based resources

Chapter 4: Workforce

- ALL therapists should be fully trained in the interventions that they are delivering or on a relevant IAPT training course
- Clinical leadership compassionate, focused on patient recovery, efficient service delivery, & staff well-being
- Other staff (admin, data managers, employment advisors)
- Regular CPD for staff focused on personal needs
- Regular clinical supervision.

Supervision

- Weekly for all clinical staff (at least 1 hr individual)
- Review ALL active cases during their treatment
- Outcome focused (including WSAS)
- Planning content of next sessions
- Support therapists
- Facilitate learning
- Identify CPD needs

Staff Well-Being

- Right working environment
- Effective supervision
- Appropriate levels of clinical complexity
- Equitable and realistic clinical time
- Training and CPD
- Well-being initiatives (training, “top-tips)
- Supportive culture

Chpt 5: Effective assessment & treatment

Assessment

- Screen for ALL IAPT conditions
- Problems descriptors
- Risk
- Identify correct outcome measures (ADSMs/MUS)
- Patient goals

Treatment

- Patient choice
- Adequate dose
- Minimal waits and prompt stepping
- Sessions outside consulting room

Under recognition of Anxiety Disorders by GPs and other professionals (APMS 2016)

Professional diagnosed CMD, by CMD in past week (as identified by CIS-R)

	CMD in past week, as identified by CIS-R			
	Depression	Phobias	OCD	Panic disorder
Ever diagnosed with CMD by professional (self-reported)	%	%	%	%
Depression	70.0	72.1	83.0	43.8
Phobia	5.9	7.2	6.0	–
OCD	7.1	7.9	13.2	–
Panic attacks	42.7	45.5	41.9	22.3
Bases	*284*	*201*	*103*	*43*[a]

[a] *Note small base for panic disorder.*

Ch 6: Monitoring Clinical Outcomes & Activity

- Explains IAPT Minimum dataset and all outcome measures
- National Standards (access, wait, outcome)
- Importance of using ADSMs and MUS scales
- Don’t game the data

Why ADSMs are essential for good therapy

- GAD scores show a modest correlation with ADSMs
- BUT GAD does not have items covering the key problems you'd want to target in therapy
  - PTSD (intrusive memories, avoidance of reminders)
  - Agoraphobia (avoided situations, alone vs accompanied)
  - Social anxiety (fear or avoidance of social interactions)
  - OCD (obsessions & compulsions).

- Therapy without ADSMs is like treating hypertension but only measuring weight, not BP!

- For conditions with marked avoidance (social anxiety, agoraphobia) PHQ/GAD can lead you to discharge too early.

How failure to use ADSM can lead to early discharge and missing the chance to transform a life

Assessment	WSAS	SPIN/PHQ Recovery	GADS/PHQ Recovery
Pre-treatment	3.56	0%	0%
Mid-treatment (6-7 sessions)	2.44	28%	71%
Post-treatment (12-14 sessions)	1.69	63%	87%
Follow-up (12 months)	1.48	73%	84%

Source: Clark et al, 2017. RCT of cognitive therapy for moderate to severe social anxiety disorder

Don’t Game the Performance Data

(Fear eats the soul: Angst essen seele auf)

Metric	Gaming
Entering treatment (access)	Single session large groups All assessments coded as “Assess & Treat”
Wait to treatment	Hidden waits between • 1st and subsequent treatment appointments • Initial group and later individual sessions • Low intensity and subsequent high intensity *See NHS Digital special reports for your data*
Recovery	Immediately discharge when patient gets to recovery threshold (rather than ensuring that patient has learned enough to stay well and maintenance programme is in place)

Chpt 7: Improving access

- Expand workforce
- Self-referral
- Service promotion campaigns and clinician outreach
- Service website
- Digitally enhanced therapies

Chpt 8: Reducing wait times

- Effective use of stepped care
- Reduce missed appointments
- Choice of treatment delivery methods when appropriate (group, digital)
- Capacity and demand modelling
- Track hidden waits

Chapter 9: Improving recovery

Multiple lessons from analyses of national data and local service improvement initiatives

Recovery Rates are higher when therapists stick to NICE recommended treatments

Self-help treatment for Depression:

Guided 50% vs Pure 36% ($p < .0001$)

Generalized anxiety disorder treatment

CBT 55% or Guided Self-help 59%

vs

Counselling 46% (ps<.0001)

Outcome Variability (Services /CCGs)

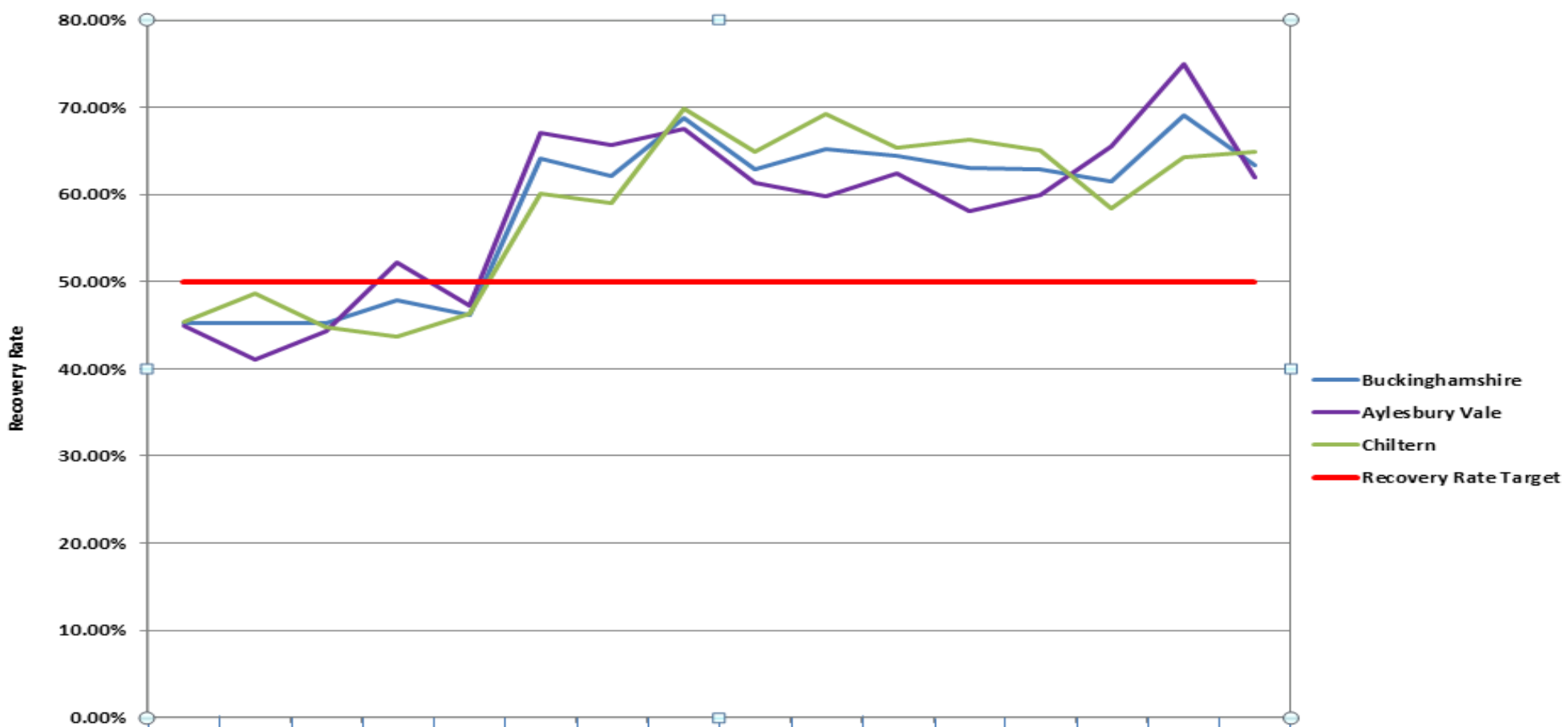
- Recovery rate: **51%** (range 35% to 71%)
- Reliable Improvement: **66%** (range 35% to 80%)
- Reliable deterioration: **6%** (range 3% to 10%)

Recovery Range	No of CCGs
Over 50%	148
45%-50%	31
40%-45%	15
Below 40%	9

Predictors of CCG level variation in Reliable Improvement and Reliable Recovery (beta regression in R)

Predictor
Problem descriptor completeness (%)
Average number of sessions
Average wait time
DNA rate (% of sessions)
Percent of patients who get a course of treatment
Social deprivation of CCG (but attenuated by above)

Plan, Do, Study, Act Service Innovation Project (John Pimm, Bucks IAPT)



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Buckinghamshire	45.32%	45.26%	45.32%	47.83%	46.24%	64.09%	62.16%	68.71%	62.91%	65.22%	64.42%	63.06%	62.90%	61.57%	69.11%	63.36%

Thank You