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Improving Access to Psychological Therapies for Depression and Anxiety in the UK

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Thank you so much for letting me be here. I've had a really enjoyable day yesterday which has set the scene for why we think the Improving Access to Psychological Therapies (IAPT) services in the United Kingdom (UK) are such an important development. I work for Oxford Health which is part of the National Health Service (NHS), which is a free service, and Talking Space is a venture that's a partnership between the NHS and Oxfordshire Mind which is a charity – it's a third sector organisation – and together, we've come together to create Talking Space. I'll explain a bit more about what the charity does and what it is that I do or we do from the Oxford Health point of view.

What I'm wanting to do this morning is gallop through, as quickly as I can, four different aspects about the IAPT programme and the way it was developed in England over the last five or six years, to talk about our own service in Oxfordshire which is bang in the middle of England and then to describe some of the impacts that our local service is having on our patients – on their chemical wellbeing, on their quality of life and on some economic impact that we're just beginning to have a look at, and then I want to return to the national picture and have a think about where we are going next.

IAPT in United Kingdom

The rationale was set out that in the UK, one in six people were diagnosable with depression or anxiety at any one time. And the figure for the UK was that only about a quarter of those were receiving treatment and only 10% of those were receiving a psychological treatment. The psychological treatments we know are often much more acceptable to patients than medication. They are as effective and in some cases more effective in the long term. They have fewer side effects and better long term outcomes. Overall we know that if we were to deliver more psychological therapies they are cost effective and they reduce the cost not only on mental health services but, as we heard yesterday, on physical health services as well. They will reduce the number of people who are receiving welfare benefits because they are not at work or because they have disability allowances.

Here are two really important people who came together in the founding of IAPT – Professor David Clark who is an eminent psychologist and developer of psychological therapies, and Lord Richard Layard who is an important health economist. They met and talked about the importance and the value of being able to deliver psychological therapies in a systematic way across the UK and the economic benefits. They wrote a seminal paper that they then presented to Tony Blair, our then prime minister. So you have a triangle of psychologist, economist and politician, and together they set up and agreed to have this programme developed which was ground breaking.

Transcript of Dr. Gerald Choa Memorial Lecture of 60th Anniversary Symposium on Mental Health on 9th December 2014.

It was launched some time ago in 2007, and there were three key aims that we would deliver by next year. I can't tell you how unusual it is to have such a long-term strategy that set out clear, simple on paper, difficult in reality, but that we would be able to do these things. First of all, there weren't enough therapists so we would need to train new therapists to deliver early evidence based therapies. We've got the ideas of what works and we were going to train some people that we would, they would only deliver evidence based therapies. This first service was for adults – there's a development now for children and young people.

They quantified how many patients we would see – 900,000 patients who otherwise would have had very little access to treatment. The standard that we were given in the health service wasn't just that we would give "all right" treatments but that we would give treatments to the standard that you get if you were a patient in a randomised control trial, so this gold standard. Most of us never dreamed that we would be able to be research therapists or get results like a research therapists, but that's what the challenge was and that in so doing we would help many of these patients come back to work and in turn come off benefits.

The services were to be accessible for all, no upper age limit, no limit because of disability or any other aspect. They had to be effective and we had to demonstrate that and because of the increase in capacity of our work force it had to be sustainable and it had to pay for itself.

This is the model. Our evidence based guidance is published by NICE – the National Institute for Health and Care Excellence. We employ therapists who are fully trained or who are training to certain accredited levels. That we would always measure patient outcomes session by session so this is the methodology that a research therapist uses. The argument was that unless we know what our patients are doing we can't treat to outcome.

Every patient would have a professional assessment and then they would be allocated according to a stepped care model. The patient is then matched to the appropriate intensity, so roughly speaking lower intensity treatments are for people with a milder problems and the higher intensity treatments are for people who have more severe or more complex problems. And as you'll see that these are the figures for now for the UK that nearly a half are having the low intensity treatments.

Each therapist must have weekly supervision and the weekly supervision is addressing outcomes as well as safety and the clinical picture that we would normally be having. It's very ground breaking because all our services until that point have been gate kept, the general practitioners (GP), had referred to secondary care services whereas now we are saying you don't need a GP referral you can just refer yourselves. This again was shocking to some.

A lot of this information that can be found on this IAPT website (http://www.iapt.nhs.uk) - there are lots of details there about what the curricula are, what the job plans are, what the services are and so on.

Stepped Care Model

The stepped care model makes an assumption that a lot of people aren't identified. We start at the bottom and they are not seeking treatment, so they may be depressed or they may be anxious but now is not the right time for them to be asking for help (Figure 1). If they go to ask for help they are either identifying themselves or they are going to GPs who obviously do a lot in the way of treating these disorders by helping people problem solving or reading appropriate literature or giving medication or telling them about how to self refer to our services.

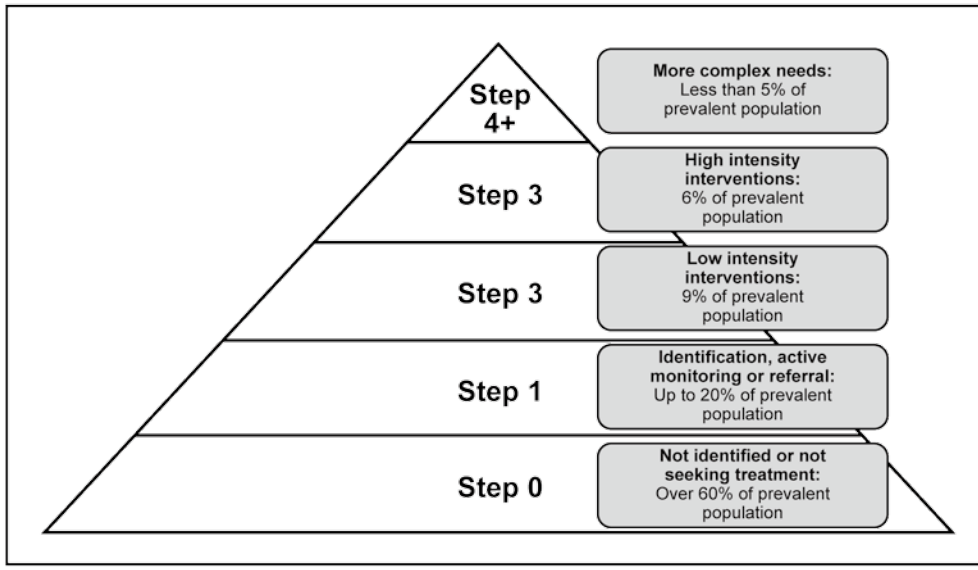

Figure 1: The IAPT stepped care model

Then the IAPT services are Steps 2 and 3. Our low intensity interventions, it was estimated, would be for 9% of our prevalent population, and Step 3 our high intensity work would be for 6%. In total the IAPT services are to deliver services for 15% that was our target to deliver 15% in any one year. There will be people, and they are the people who previously have been seen in the very top part of the triangle, who have more complex needs and might need more specialist help. They're the top 5% of the population who are anxious or depressed.

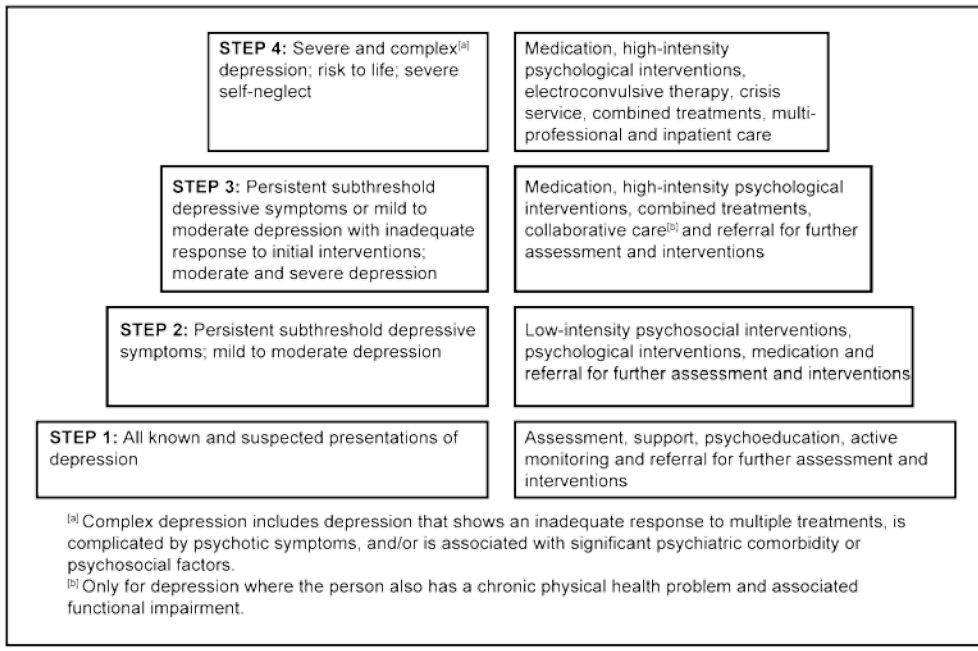

Figure 2: The IAPT stepped care model for depression

Talking Space in Oxfordshire

Now I'll say a little about what that meant for a service like ours. I've been running a primary care counselling and primary care psychology service where we have people in different GP practices. We were able to bid for monies because I had some psychologists who by and large were using CBT, one of the evidenced based treatments, and who could provide supervision for the new staff. You couldn't get the money unless you already had the supervisors in place.

Oxfordshire is in the middle of England, and, as I've said, we bid for money together with Mind. At that time Mind was already running CBT groups and classes, evening classes, in the community and we thought that together their low intensity interventions would sit well with our more experienced therapists who would be the supervisors and therapists on high intensity interventions. Politically that was a good move and was attractive to the founders and Talking Space was born.

Since 2009 I've been very busy. We've trained over 90 staff and we've treated over 23,000 people. These are numbers we couldn't have dreamed of. We're using clinical outcome measures at every session and we're getting to this magic target of 50% recovery rates as we might expect from the randomised control trials. There's a target, we weren't quite sure when we started how many people we would be able to return to work but this is the breakeven point in terms of welfare, economic recovery. We're meeting that and it's very pleasing to know that we're getting people back to work.

This is our website that's got more details of what we're providing and where (www.talkingspaceoxfordshire.org).

Our model is that Oxford Health and NHS hold the contract and I'm the clinical lead and we provide the clinical leadership and the clinical governance for the whole organisation. We provide daily supervision and duty supervision and we provide the buildings and the administrative support including telephones and the computers and so on. Oxfordshire Mind is subcontracted and they deliver all the Step 2 interventions and their workers are called psychology wellbeing practitioners.

It was absolutely important that they weren't in a separate service as in some parts of the UK these services are delivered separately. But because so many of our patients move between the steps, it was really important that they were in the same building. If there is only one thing I did it was that to make sure that they are in the same building and that we talk and we work absolutely closely together. We use the same clinical database and all the electronics that go with that. We have training meetings and business meetings and everything together.

Where we are now is that we have over 7,000 referrals a year, only 8% of those are coming from GPs. So nearly everybody just picks up the phone or they get to us on the internet. Their first step is that they phone us and then we book an appointment where they are screened. So nearly all of them have a telephone assessment unless there are very good reasons not to – they're hard of hearing or they have mobility problems. At that point about 20% of people are closed because it's not the right time or not the right service or they actually have problems that are more to do with drugs and alcohol or eating disorders, all sorts of problems that we don't see.

50% start their treatment at Step 2 and then 30% move to Step 3. So they all have Step 2 assessment, that's our psychological wellbeing practice that we must do that. And a large part of what we do is knowing an awful lot about local resources so it may be that they get signposted to housing or financial advice. When people have had their treatments then we always follow them up as you would in a randomised control trial to see if it works and sometimes it's necessary to refer on. At any one time we've got about 2,000 cases.

Measuring Outcomes

I've mentioned the importance of using clinical outcome measures at every session and this is quite extraordinary that we have measures on 98% of our attendances. Some patients don't like that but they soon come to realise how helpful it is for us and for them to know in what ways they are improving or not improving. We have this bespoke clinical recording system – there are two in the UK – that were designed especially for IAPT. There are particular ways of recording, so I'll show you later when I'm comparing our results with other services' results we're using the same database, data is collected in the same way and we know we are matching like with like. Services might be different but the measurements are the same.

As I've said we have clinical supervision and we are using this idea of 'least intervention first time' (LIFT), so that people are matched to what they need. It's difficult doing psychological therapy. You don't want to be having to have all the demands that requires if you don't need it. Just go in at that level.

And we're very, very careful at looking at safeguarding people's own risk and safety but we take a lot of care to think about their children or their old people, their families or other people at risk of harm or neglect and there's a whole system around that.

We heard yesterday that other people are using the PHQ9 to measure depression and we use also the GAD7 and there are other standard measures that we use every single time. We always ask about whether people are using medication or whether they've gone back to work and we use a work and adjustment scale to have a look at the impact of the quality of life away from depression and anxiety.

Figure 3 shows the screen shot of our database. This is showing somebody's PHQ9 and GAD7 scores were coming down. But something happened in November and the person started getting unwell again. Then the patient was kept in treatment and the scores came down again, with anxiety scores a bit more fluctuating. This is the sort of thing that you have on the screen. For every supervision you have up when you are talking to the patient on the phone or in your surgery, you can have a look at the scores together and try to make sense of them. If somebody is deteriorating, then you have to take that to supervision. If someone is failing to improve or if results are staying the same, then often people have to step up to the next level, and obviously we are looking out for risk.

Low Intensity Intervention

Figure 4 shows the IAPT stepped care model. It's a busy slide but I am going to focus on Step 2 here, the lower intensity work, and then I'll come on and talk about Step 3 later.

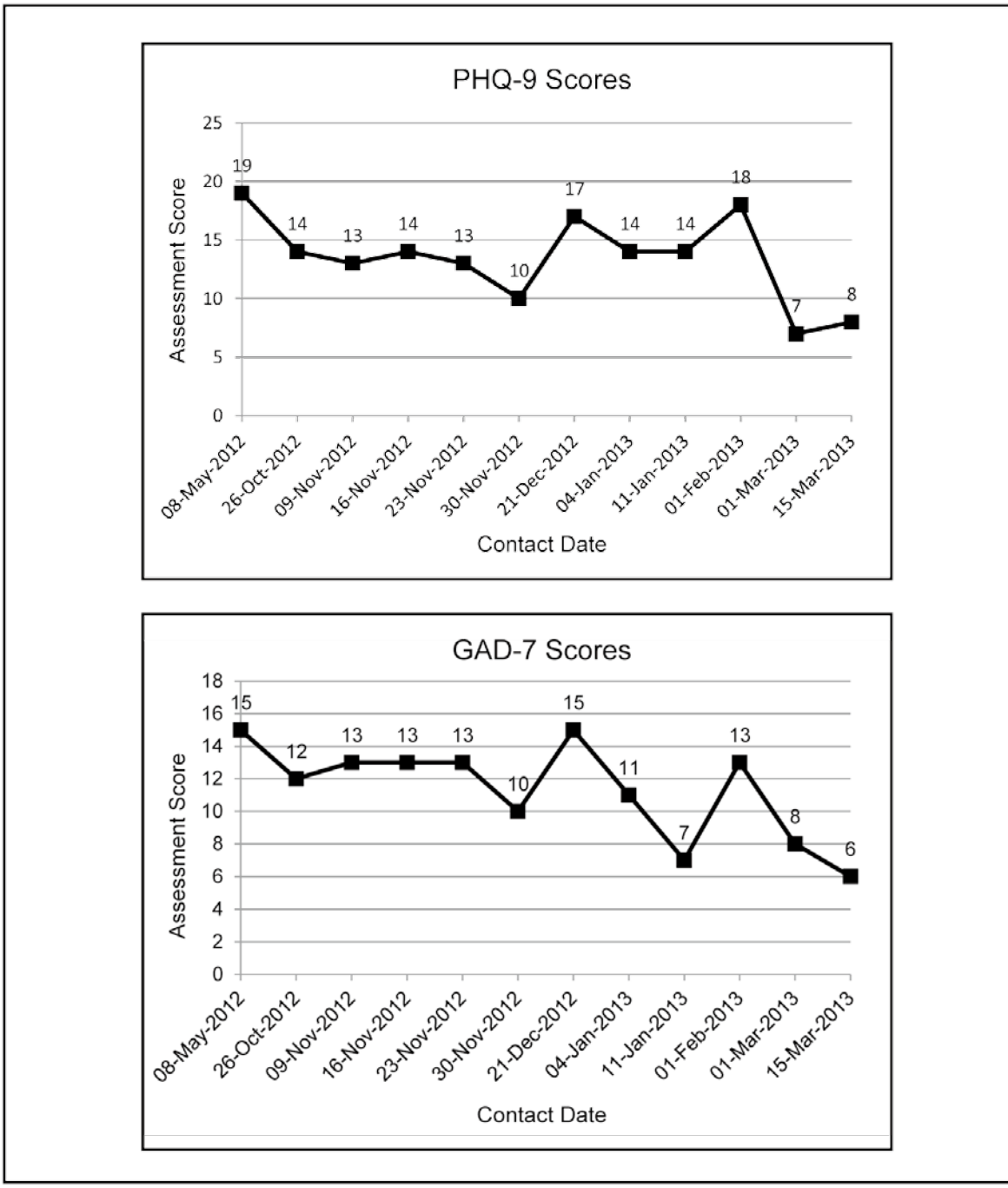

Figure 3: Comparison of PHQ9 scores and GAD7 scores

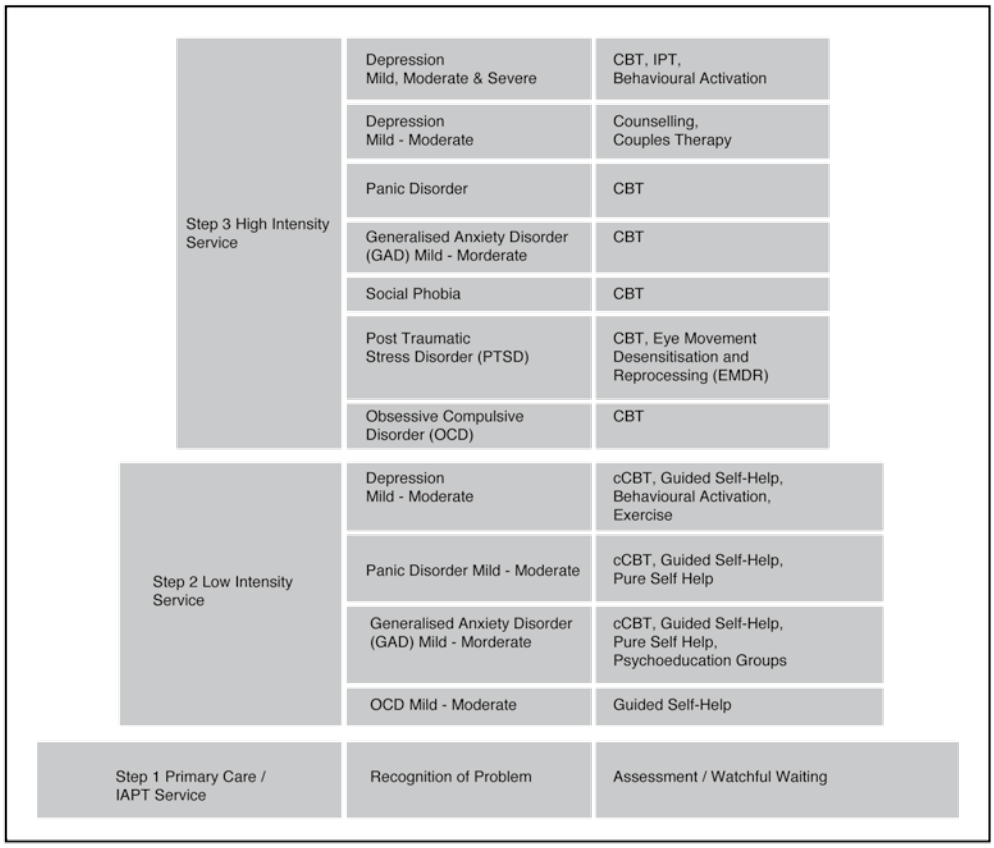

Figure 4: The IAPT stepped care model

Step 2 showed the lower intensity interventions here. At the moment that's nearly all the people who are depressed start here and we have panic disorder, generalised anxiety disorder and OCD. They are given prior to most of these interventions are either CBT or behaviourally based and it's all based on guided self help. There's quite a lot of evidence showing that pure self help is available but it doesn't really work. So unless there's guidance and support over the phone or in face to face meetings, "Did you understand it?", "Have you been able to try anything this week?", "Is there anything getting in the way of you trying things?" those sorts of questions will help people enact the things that will make a difference.

As I've said, these are delivered by our psychological wellbeing practitioners and I thought I'd just say a little bit about who these people are. They need to have some previous mental health experience, they are often graduates and we employ them four days a week and they go to university for one day a week through the year. They adhere to a national syllabus and there are three core modules. One is all about assessment and engagement that they see, on the phone, they come into contact with thousands, well hundreds of people each so they have to be very engaging and they have to ask a lot of questions in a way that isn't off putting, so they are trained to do that. They are trained to think a lot about the diverse population that we have and obviously they are trained in the treatments that they deliver.

In our service we do a lot of this work by providing courses. So there are evening

classes and people come to classes. Mostly people think they are not going to like these, so we have to sell them in a way to get people there. But eventually people who come said that it's really helpful/reassuring to meet other people suffering from the same thing, it's nice to talk within the group, it's friendly presentation, useful and informative, and they learnt things that helped them overcome their problems. So the large volume of our low intensity work goes into these sorts of CBT guided self-help courses.

We use computerised CBT. Some of you might have come across 'Beating The Blues' which has been around for some time and some of our patients say it's a little out of date now. We are hoping to move to 'Silver Cloud' which is another supported programme to make space for healthy mind. There are eight modules in 'Beating The Blues'. People are expected to listen to the packages themselves at home and there is phone call support, so 'How did you get on?', 'What did you do?' and so on.

Then there are other guided self-help materials, like those from Northumberland, Rethink and Cedar. They are typically self-help programmes of 4-6 30-minute sessions and are available on the website. These are readily available, they are free and we use those often in a face to face meeting to give the information out and then follow it up with a phone call.

The majority of our patients have just guided self-help, and a large number of people are getting better at this stage, with 70% success rate or recovery rate at this level.

High Intensity Intervention

People who have more complex problems or more severe problems or people who haven't responded to the light touch will have high intensity interventions. These are delivered by properly trained CBT therapists and psychologists and mostly these are delivered face to face. Where we can we run groups with longer, more intense and more complicated syllabus. But the majority are working with individuals at this level. As you'll see the majority of the work is CBT but we also provide Behavioural Activation for depression, some interpersonal therapy for people whose problems are more in their relationships with others.

A different organization provides counselling for depression which is a second order intervention which we recommend once they've tried CBT, if CBT hasn't worked. We don't yet provide couples therapy but we are looking to train more staff to do that. We just have one therapist at the moment who's trained in eye movement desensitisation and we process him as an intervention for post traumatic stress disorder. Also in the NICE guidance to help people recover, to establish recovery if they've had episodes of depression and mindfulness based CBT is available as well.

Our CBT therapists also have mental health experience, and they need to have core profession so they are either nurses or OTs or social workers or equivalent. They've also done a one year course at University for two days a week while they're training and they are trained with a national syllabus. They have supervised practice and are trained in seven protocols. They are trained in engagement with some of the therapeutic things. Figure 5 shows the seven protocols that are recommended in the NICE guidance at this moment. We have an eye to a new NICE guidance that is coming out and might have to change what's coming over the hill.

- Seven protocols for CBT
  - Martel (2008) Behavioural Activation for Depression, (NICE 2013)
  - Beck, Rush, Shaw & Emery (1979) Cognitive Therapy for Depression, (NICE 2013)
  - Clarke and Ehlers (2004) for PTSD, (NICE 2005)
  - Whittal, Robichaud & Woody (2010) for OCD, (NICE 2005)
  - Clark & Wells (1995) or Heimberg (2006) for Social Anxiety (NICE 2013)
  - Dugas CBT for Generalised Anxiety Disorder, 2007 (NICE 2011)
  - Salkvoskis for Health Anxiety (1997)

Figure 5: Cognitive Behaviour Therapy

Figure 6 shows the number of people entering treatment, completing treatment and recovery since we started in 2009. We started modestly and have been on the up in terms of entering treatments, the blue line. There was a change in service delivery in 2010 where some of the counsellors that we employed moved to different organizations which accounted for that drop. Then you will see that we're moving on.

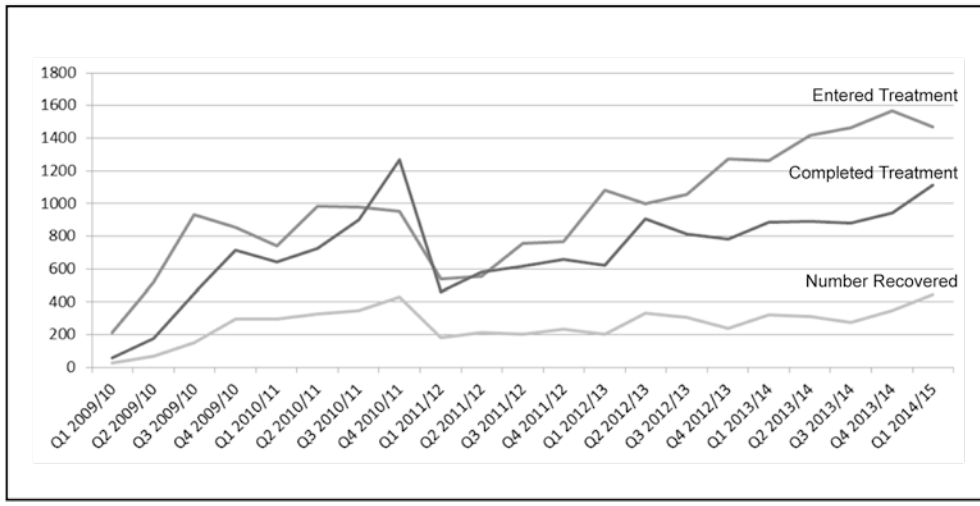

Figure 6: TalkingSpace – Numbers of people entering treatment, completing treatment and recovering 2009-2014

Value Added Initiatives

We're doing a number of other things as well. The basic model would be if you went to any other IAPT services in the country it would look pretty the same as I've described and some of them would have some of these other features as well. We provide employment support (Restore). There is a particular worker to liaise, provide

signposting and support for people struggling to stay in employment. He works with people who are in work but on the edges of losing their job – they're off sick or they're having problems with getting back to work. He would mediate, get people on phased return to work and provide support when it's needed.

We're doing a lot of work to try and improve the access for older people. Nationally it's difficult for older people to get referred, or want to be referred, or when they are referred to get the right sort of help that's age appropriate.

We were given extra money two years ago because we wanted to improve our offer to people with long term physical health conditions (Pathfinder site) to see how we needed to adapt our materials and I'll say a bit more about the work we've done with project vocations. And then, we're doing some work to help GPs in their consultation skills to help them recognise anxiety and depression more consistently, more reliably, but also to know what to do next.

Figure 7 shows how many people we are getting who are moving off sick pay/benefits so again we are meeting our targets here.

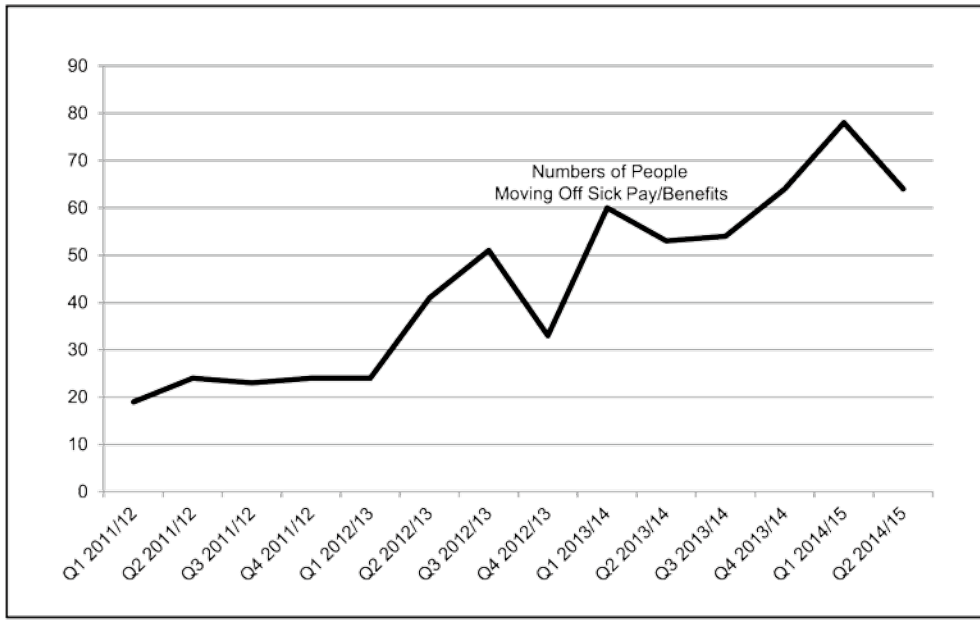

Figure 7: TalkingSpace Numbers of people moving off sick pay / benefits 2011-2014

Key Achievements

As I say we are seeing a large number of people every year. We received around 7,600 referrals per year, and over 5,600 are coming into treatment. Our clinical recovery rate was over the national average of 50% in a consistent way and a large number (51%) of those people are showing reliable improvement as well. Over 200 people are moving off sick pay and benefits and over 90 staff are trained to deliver NICE-recommended treatments.

So, what do people think about this? The national lead Prof. David Clark said "TalkingSpace is seeing a staggering number of people with on-target recovery rates". That was a few years back. And last Friday, just

when I was getting ready to come here thinking that I had quite enough to do, the Minister of Health said that he was coming to visit from London so we quickly did a tour and he said we provide "fantastic service, very impressed" and that it was "an inspirational collaboration".

What our patients say? Figure 8 shows some of feedbacks from the patients who used our services.

What GPs say? They like it because patients are self-referred, there's very little work for them to do, and they appreciate what we are doing. One of the Oxfordshire GP said, "TalkingSpace is fantastic for the level of support it provides to patients ... the overall improvement my patients have made through the service has been phenomenal".

Developments

I'll just show a little bit about some work that we did on our Pathfinder Project with people with cardiac problems. Again we heard yesterday that you're two to three times more likely to have anxiety or depression if you have a long term medical health problem. And also having a mental health problem increases the morbidity in patients with long term conditions and a large amount of money is spent on this kind of group. So we set up a feasibility study, we called it Heart2Heart, to see if there was a cost effective way of providing services, of integrating both physical and psychological care. Of course the target was people coming out of acute hospital after a heart attack and we were having a look whether we could do stepped care. It's the same sort of model except that we were working in the cardiac clinics. In Step1 it was cardiac nurses who were screening for anxiety and depression (Figure 9). At Step 4 it was a clinical health psychologist who was helping us provide all the clinical supervision of Steps 1, 2, 3 and 4.

I'll just skip on to show you that the patients got better and we had a look at the difference between those people who have a heart attack (Table 1 & 2). They're getting better on depression and anxiety and adjustment measures as people with heart failure, so similar improvements but not quite as great. Then we had a look at what impact that would have on the amount of hospital care they were getting. This is not a randomised control trial, this is not compared with a control group, and this is a service evaluation that we are having a look at indicative costs of going to hospital afterwards.

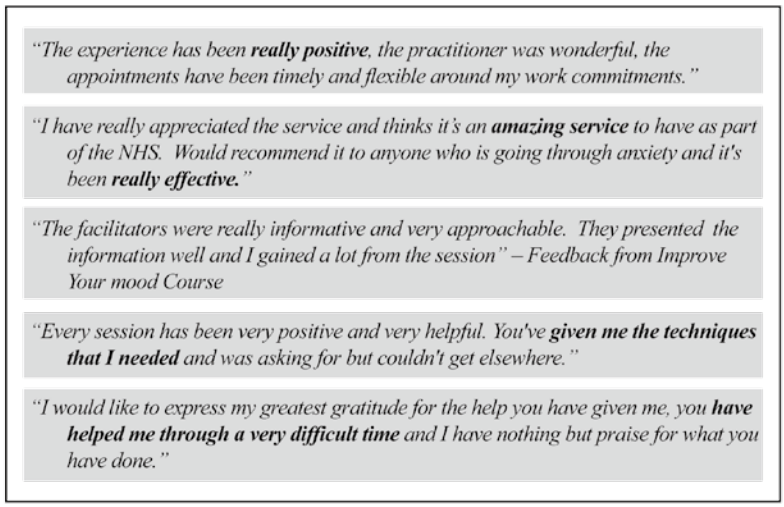

Figure 8: The comments from patients

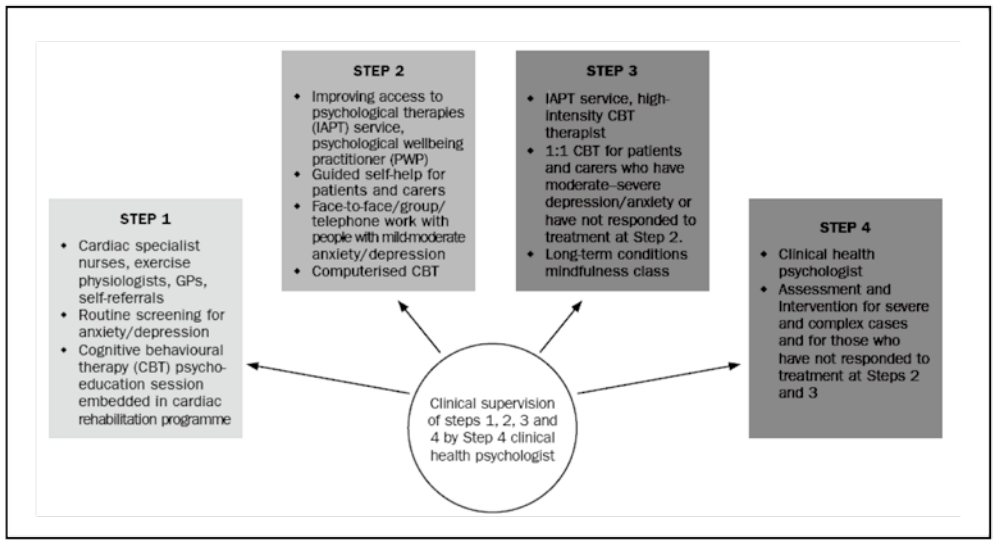

Figure 9: The Heart2Heart Stepped Care Model

Table 1
Pre and post median and range scores for patients with MI who completed and withdrew from therapy (N=67)

	Median		Range	
	Pre-therapy	Post-therapy	Pre-therapy	Post-therapy
PHQ9	10	5	25	23
GAD7	9	3	21	20
WSAS	13	6	37	32

Improvement is statistically significant p = .000

Table 2
Pre and post median and range scores for heart failure (Non-MI) patients who completed therapy (N=39)

	Median		Range	
	Pre-therapy	Post-therapy	Pre-therapy	Post-therapy
PHQ9	8	2	22	18
GAD7	7	2	21	18
WSAS	11	6	37	30

Improvement is statistically significant where p = .000 for PHQ9 and GAD7 and p = .012 for WSAS

If you read Table 3 from the bottom up, it's showing these are the people who have a heart attack. If they came to us and were largely untreated, either because they didn't turn up for appointments or they just had one appointment, then the savings after their treatment, having cardiac rehabilitation as well, were £2,800. But if they had treatment with us, the savings were about another £2,000 greater. So with this group, with pretty low intensity interventions, on average it was about another 7 hours of treatment, we could save nearly £2,000 on their secondary care needs. There are other ways we could look at that and we need to look at that in a bit more detail but it's an exciting first step and gave us an idea that we could do this work and could demonstrate that we could save money and we're hoping to evaluate that in a more systematic way.

Table 3
Secondary Care Usage Data for MI Patients

Cost of ALL Hospital Visits (A&E, Inpatient and Outpatient)	
	Reduction in cost per patient £
Treated group i.e. 2 or more sessions (N=34)	£4,793
Untreated group i.e. DNA or 1 session (N=29)	£2,814

Way Forward

I'm going to finish now by just telling you a bit about how we fit in, how does Oxfordshire fit into the national picture. Figure 10 shows that in just the last couple of years, the people completing treatment is over 100,000 and the people who are recovering is 44,000. So again we are moving on up all the time. It's a machine that's started, it's got a momentum, it's going on, going on up.

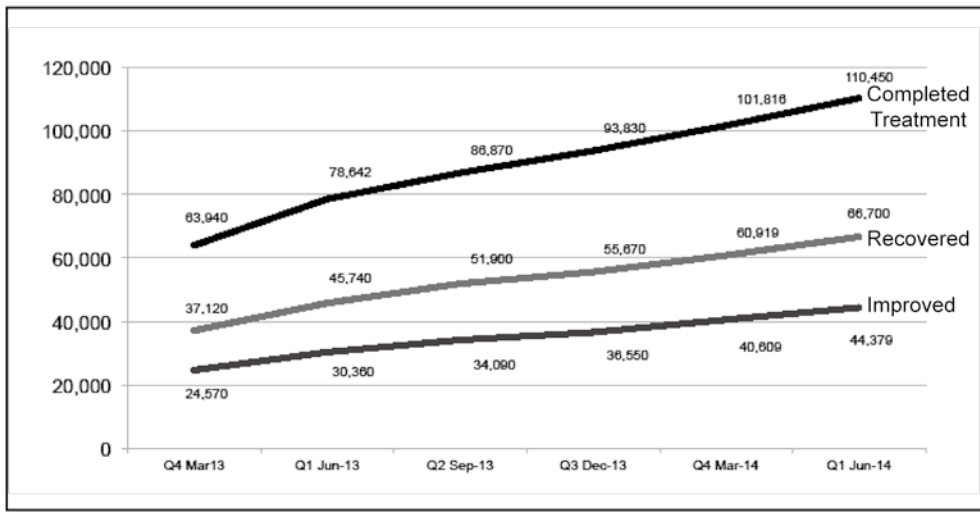

Figure 10: National Percentage people improving and recovering 2013 to 2014

We are submitting our data now every month into a national system in exactly the same way as every other service is submitting its data. It's all anonymised but any county or any clinical commission group can have a look at how its county is doing. The outcomes of the services of Oxfordshire, a combination of our service Talking Space and the counselling service, are that: a) access to IAPT service – 13.1 (27.9 – 3.5, national average 9.5), b) patients finishing a course of training – 56.6 (87.3 – 7.9, national average 51), c) rate of recovery – 50.6 (64.7 – 24.6, national average 45.5), and d) reliable recovery – 66.1 (72.6 – 33.3, national average 61.9). So this compare, contrast and, dare I say it, slightly compete will actually make sure that our services continue to get better and better.

In sum, we're getting lots of patients in but we're not finishing quite as many as we would expect and that's partly because we haven't been given as much funding as some of these other services. We're doing a lot of work now, we're coming together in a network, in a group with our local providers, five or six of us coming together in an academic health science network fortunately we're led by David Clark who's the national leader. In that, we'll have a look at what are the ways that we can drive up our recovery rates, what are the ways that we can reduce variation and increase good practice.

On the aspect of training, there's a national curricula for training therapists and CBT therapists. There are competency frameworks so it's not just what do you get taught, it's what do you end up being able to do. Some of the courses didn't achieve accreditation, so it's not that all courses that were set up did a good job. Some of them were closed down and not all therapists that undergo training pass. Only those therapists that meet targets or competency levels can stay on, so that when your mum or you go and get therapy, you're going to be seen by the best therapists. So far it's focussed nearly wholly on CBT but we will consider training up non-CBT therapists later.

I've talked about the activity standards. There are quality standards for service as well. IAPT services are based on stepped care principles in all areas of the country. There are published quality standards for commissioners so that they know if they have to buy a new service what a good service look like. And these standards are available on the website.

In the UK we've got a general election next year so we'll have a look at a new parliament, what will the next steps be. Trying to reduce variability in recovery rates and increase recovery rates. We've reached the increase access to 15% by 2015. That was the target, we said we were going to that and we've done it. And next is to campaign for an increase by another 10% over the next five years, in particular looking at people with serious mental illness, including integrated physical and mental health care, and boosting programme for IAPT for children and young people.

Where next? The editorial in Nature 2012 wrote that the IAPT programme "represents a world beating standard, thanks to the scale of its implementation and the validation of its treatments". This is an important scientific journal saying that the science upon which this is based and all the data collection and evaluation makes this world beating. We know that there's international interest from Norway and Sweden, Canada, USA and maybe Hong Kong.