Commissioning talking therapies to meet need

A briefing from the We Need to Talk coalition
November 2014

I was very relieved to be offered a talking therapy and it really made a difference. It has given me tools to support myself if I become ill again and to catch myself before falling so far next time.

Mind survey respondent

This briefing, prepared on behalf of the We Need to Talk coalition, provides commissioners with information about the benefits and effectiveness of talking therapies, and highlights considerations to make when commissioning services.

In England, six million people have anxiety and depression and a further 1 in 100 have a severe mental illness. One in 10 children and young people live with a diagnosable mental health condition[1]. Yet 75 per cent of these people are not receiving appropriate treatment[2]. Early access to the right type of psychological therapy can make a huge difference to people's recovery and prevent problems getting worse.

The Government's Mandate to the NHS commits to putting mental health on a par to physical health and giving everyone timely access to evidence-based services[3]. Clinical commissioning groups (CCGs) with their local authority partners are the local leaders who can make this a reality. In preparing five year strategic plans, now is the time to ensure everyone has access to a choice of evidence-based psychological therapies when they need them.

About the We Need to Talk coalition

The We Need to Talk coalition is a group of mental health charities, professional organisations, Royal College and service providers that believe in the effectiveness of psychological therapy. Together, we are calling for the maintenance and development of these treatments on the NHS.

We want the NHS in England to offer a full range of evidence-based psychological therapies to all who need them within 28 days of requesting a referral.

Waiting times

From April 2015, new waiting time targets will mean 75 per cent of people referred to Improving Accessing to Psychological Therapies (IAPT) should receive treatment within 6 weeks, with 95 per cent of people being treated within 18 weeks[4] .

- The impact of waiting for psychological therapies can be devastating, affecting people's relationships, ability to stay in work and their long-term mental health. Getting the right treatment at the right time improves outcomes and brings longer term savings to the local NHS by reducing demand on other services.
- However, our 2013 survey found over half of people are waiting longer than three months to access therapy through the NHS[5]. A survey of NHS psychotherapists also showed 57 per cent of therapists reporting increased waiting times for services[6].
- Our 2014 survey found, that while waiting for therapy: 67 per cent of people became more mentally unwell, 40 per cent harmed themselves and 1 in 6 attempted to take their own life[7].
- In a recent Pulse survey of 500 GPs, 84 per cent of respondents said they were forced to prescribe at least sometimes because the local IAPT service is not able to help a patient, with 50 per cent saying they were forced to do this 'often' or 'all the time'.

Have you checked:

- ✓ What are the waiting times for both IAPT and non-IAPT psychological therapies in your commissioning area?
- ✓ Are people able to get timely access to mental health services, when they need it?

Choice

Being given information and choice about the type of treatment you receive, as well as when and where you receive it, promotes engagement and helps recovery. Different therapies work well for different people, so it's crucial that everyone is able to choose the type of therapy that's right for them.

- Our 2014 survey[7] found only 15 per cent of people were offered a full choice of NICE-approved therapies[8] with 56 per cent not offered any choice. It also found a disproportionate focus on Cognitive Behavioural Therapy over other therapies.
- People who had a full choice of therapies were over four times more likely to report feeling well after treatment than those who weren't offered any choice[7]. It is vital that choice is available if the full benefits of treatment are to be realised.

Have you checked:

- ✓ What psychological therapies are available through the NHS in your commissioning area?
- ✓ Are people offered information about different types of therapy and a choice based on their preference?
- ✓ Can people choose when and where they access therapy and make an informed choice about the therapist they see?

Access

Psychological therapies should be available to everyone who needs them with clear and well-publicised referral routes. In reality, some groups find it harder to access therapy or to find a therapy suitable for their needs. And some groups who could benefit from therapy do not receive it. The CCG Outcomes Indicator Set contains a specific measure of access to psychological therapy services by people from Black and minority ethnic (BME) groups and this should be seen as a priority for commissioners.

- People from BME communities, older people, homeless people with co-occurring substance dependencies, people from LGBT communities, and people on the autistic spectrum face greater barriers accessing the treatment they need.
- Timely and accessible treatment should also be made available for children and young people, where early intervention can have significant impact on the future mental health of the adult population and reduce demand on adult services.
- NICE guidelines recommend psychological therapy for people with severe mental illness (SMI), such as psychosis, bipolar disorder, personality disorders or eating disorders. But often, the IAPT service in their local area is not appropriate and therapies that meet their needs are not routinely available within secondary care. The Department of Health's four-year plan of action for talking therapies identifies this as a key area for improvement[9]. Local CQuINs (Commissioning for Quality and Innovation payments) can be a good way to incentivise providers to reach out to these groups.
- Psychological therapies can also help to reduce the impact of physical health costs, such as diabetes, to the local NHS. Treating the physical health needs of people with depression or anxiety can cost 50 per cent more than treating physical health problems of people without mental health needs. Providing support to these people can reduce costs[10].
- People with long-term conditions, such as diabetes, arthritis and heart disease, have a high risk of developing common mental health problems and those who do have co-morbid depression and anxiety die sooner and have poorer physical health.
- About 70 per cent of people with medically unexplained symptoms have anxiety or depression. On average, their healthcare costs are 50 per cent more than other people[11]. Extending access to appropriate psychological therapies to this group can reduce GP consultations, outpatient visits and A&E attendances[12].
- By engaging widely with local communities, commissioners can ensure that all groups have equality of access to psychological therapy services that meet their needs.

Have you checked:

- ✓ What are the access rates to IAPT and non-IAPT psychological therapies for the groups listed above?
- ✓ Are children and young people able to access appropriate psychological therapies?
- ✓ How are self-referral routes publicised within local services and in the wider community?
- ✓ Are patients with long-term physical health problems and medically unexplained symptoms routinely offered psychological therapies?
- ✓ How do you engage diverse groups in the local population to ensure your services meet their needs?

Recovery and quality

The CCG Outcomes Indicator Set will measure recovery following talking therapies for all ages. These data will be comparable between CCGs.

- Access to high quality therapy delivered by qualified, supervised and experienced therapists gives people the best chance of recovery.
- Half of the respondents to our survey[5] felt the number of sessions they were offered was not enough, undermining their chances of achieving a successful recovery.
- Some commissioning models, such as Any Qualified Provider, may exert cost pressures on service providers that make it difficult for them offer high quality services that meet NICE guidelines and retain good staff[13]. Commissioners can ensure people are offered the help they need to recover by choosing to invest in high quality services and the people who deliver them.

Have you checked:

- ✓ Are local people getting enough sessions to enable their recovery?
- ✓ What are the recovery rates in the services you offer – both IAPT (target 50 per cent recovery) and non-IAPT?
- ✓ If patients return multiple times to the same services, are there alternatives available to support their recovery?
- ✓ Do your services meet the quality assurances of the IAPT programme or non-IAPT equivalent?
- ✓ Are your patients satisfied with the psychological therapy services they use?

Understanding and meeting local need

NHS England's IAPT Quality Premium is payable to CCGs achieving access levels of 15 per cent by March 2015, which should be the minimum target for commissioners.

- Psychological therapies should be commissioned to meet the needs of communities, as identified through Joint Strategic Needs Assessments (JSNA). JSNAs should capture the full picture of health, including the needs of homeless people which are often overlooked[14]. Long waiting times and a lack of access to services can be signs of unmet need, which is estimated at 75 per cent nationally.
- Currently the cost to the NHS of not treating mental health problems is about £13 billion[15]. Increasing the provision of psychological therapies may involve some upfront costs but can lead to net cost savings to the local NHS.

Have you checked:

- ✓ Does your JSNA capture the full scope of local needs?
- ✓ Are your commissioning plans based on the findings of the JSNA and are they adequate to meet the identified needs?
- ✓ How much do you currently spend on IAPT and non-IAPT services and how does this compare with neighbouring areas?

Case Study 1: City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS)

Designed by GPs, the PCPCS offers training to GPs in the London boroughs of City and Hackney and a range of psychological therapies to patients with medically unexplained symptoms, personality disorders and chronic mental health problems. Many of the people it sees have poor physical health and experience social difficulties. Nationally, these types of patients are typically frequent users of local health services.

The service receives 40–50 patient referrals a month. Following treatment, improvements in mental health were reported in 75 per cent of patients and significant recovery was achieved for 55 per cent of patients. A Centre for Mental Health economic evaluation found that the service also reduces costs in other parts of the NHS – through reducing the number of GP consultations, A&E visits, outpatient appointments and hospital admissions amongst users of the service. The typical saving made through this reduction in use of other services is estimated to be £463 per patient in the 22 months following treatment.

Treatment typically lasts for 12–13 sessions, at an estimated cost of £1,348 per patient. The service has an estimated cost of £10,900 per 'quality adjusted life year' (QALY), less than half of the threshold set for cost-effectiveness in the NHS.

Dr Geraldine Strathdee, National Clinical Director for Mental Health, has said: "This kind of innovation should be the hallmark of a twenty-first century NHS. Instigated by GPs, and based on clear evidence of unmet need, the PCPCS offers new hope to people we have not served well".

Case study 2: Mind in Harrow IAPT Step 2 Low Intensity Service

Mind in Harrow provides the Step 2 'low intensity' provision of the Harrow IAPT Service, which they have been delivering since 2010. The service includes guided self-help in a choice of one-to-one or group sessions. Delivering the IAPT service as a partnership between the NHS and a third sector provider has enabled the service to build on their strong, existing relationships with the local BME communities, and ensure the service is able to meet their cultural needs.

Waiting times

Harrow IAPT service waiting times have been reduced from 12 weeks in 2010, to four weeks in 2014. As a result of the reduced waiting times, around 800 people accessing Mind in Harrow's Step 2 'low intensity' service during 2013/14 were more likely to access the service, getting the support they needed earlier.

Access

In 2014, the Harrow IAPT Service started to accept self-referrals, giving Harrow residents easier access to an assessment of their needs for psychological therapy, and promoting equity of access within the community. In order to ensure the needs of the local population are met, Harrow Mind delivers their group sessions at different community venues across the borough. They will be expanding to ensure they are able to reach a greater proportion of older adults, and BME communities in future.

Recovery and quality

The Harrow IAPT Service exceeded the national recovery rate target of 40 per cent by achieving 43 per cent per cent average across the whole service in 2013. The people who use their service have access to the appropriate number of sessions for their needs, and as a result are able to address their mental health problems. Over 1,500 people accessing the Harrow IAPT service during 2013/14 had a better chance of experiencing reduced anxiety and/or depression.

Endnotes

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11. Department of Health (2008), Medically unexplained symptoms positive practice guide.

12. Centre for Mental Health (2014), Managing Patients with Complex Needs.

13. Pietroni, P et al (2013), Mental Health's Market Experiment: Commissioning Psychological Therapies Through Any Qualified Provider University of Chester

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