Improving access to psychological therapies in England

Published Online
December 7, 2017
http://dx.doi.org/10.1016/S0140-6736(17)32158-X
See Online/Articles
http://dx.doi.org/10.1016/S0140-6736(17)32133-5

Most people with mental illness worldwide receive no treatment at all.[1] The number benefiting from effective treatment is even fewer—eg, as low as one in six people with major depression receive effective care in high-income countries, and one in 27 people in low-income or middle-income countries.[2] For mild-to-moderate depression, the treatments of choice are psychological therapies.[3,4] Are there any examples of a health-care system successfully scaling up evidence-based practice for such common mental disorders? Yes: evidence is emerging that the Improving Access to Psychological Therapies (IAPT) programme in England fits this bill as reported by David M Clark and colleagues in *The Lancet*.[5]

Launched in 2008, the IAPT programme provides psychological treatment centres across the country and these centres offer individual or group therapies—largely cognitive-behavioural treatment (CBT) approaches—to people with anxiety or depressive diagnoses.[6] Initial assessment, often by phone, determines whether a client is suitable for IAPT, needs low-intensity or high-intensity therapy, or needs to be referred to specialist mental health services.

The programme is unusual because of several features. First, standardised and manualised evidence-based intervention protocols are used, with intensive clinical supervision. Second, routine outcome monitoring occurs at each clinical session with the results fed back to staff and clients. Third, treatment is free at the point of care with the service funded by the tax-based National Health Service, with 209 teams distributed across the country (with an investment of £400 million from 2011 to 2015).[7] Fourth, clients might receive both psychological and pharmacological treatment at the same time. Finally, the IAPT programme aims to achieve quantified access and recovery rates. The scale of the programme is remarkable, with the latest data showing that about 950 000 people a year access IAPT for an initial assessment and advice, of whom more than 537 000 receive a course of therapy.[8]

Clark and colleagues' study[5] reports how service-level characteristics, such as the waiting times at individual IAPT teams, affect the outcomes of care and they show that better outcomes are not only associated with practitioner-level factors but also that service-level characteristics influence outcomes. With the IAPT programme, clients with clinical diagnoses had positive effects, treatment sessions increased, and some teams were able to accept more referrals. Conversely, outcomes were worse when waiting times were longer and when fewer therapy sessions were attended.

However, much more is still needed. The original prospectus for IAPT relied heavily on delivering a strong return on investment from reductions in "presenteeism and absenteeism",[9] namely greater workplace productivity as a result of the treatment of employed people with anxiety or depression. However, little evidence has emerged that such productivity gains have been realised.[10,11] In terms of access, in many countries about a half of all people with anxiety or depression either do not consider that they have a difficulty or choose not to attend treatment sessions.[2] Therefore, system-wide measures are needed to increase help-seeking.[12] Avoidance or reduction of disparities in the access to therapy is also vital—eg, related to age, gender, ethnicity, or social position. The expansion of the range of evidence-based psychological therapies provided, from the original focus on CBT, now needs to be accelerated,[13] along with an intensification of the provision for children and young people, older adults, and people with psychotic disorders.[14] Increasing recognition of syndemics suggests that IAPT services need to explicitly address comorbid mental and physical conditions.[15] Although IAPT teams in England are likely

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to have made important contributions to the recently increasing treatment rates for adults with anxiety or depression (from 24% in 2007, to 37% in 2014),[16] the longer-term goal for all services provided for people with mental illness must show real reductions in the overall prevalence of mental health problems.[17]

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I collaborate with Article author Richard Layard on initiatives related to global mental health, and I receive no payment or remuneration for this work. I declare no other competing interests. I thank Katarina Gerocova, a current IAPT practitioner, for discussion about how the programme actually works on the ground; this discussion informed my Comment.

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