Talking therapies: can the centre hold?

Can centralised programmes provide better care more cheaply?

At a time when centrally driven initiatives in healthcare are out of fashion, one at least survives—improving access to psychological therapies (IAPT). Inherited from the last government and backed strongly by the new one in spite of its commitment to localism, this programme aims to make talking therapies for depression and anxiety universally available throughout England.

But in spite of strong support for it in the recently published mental health strategy, all is not quite as rosy as the health minister Paul Burstow would wish. Nick Clegg, the Liberal Democrat leader (isn’t it marvellous how top politicians can always find the time in their busy lives to announce good news?), promised an additional £400m for the programme to complete the training of therapists and the roll out of the programme to the whole of England by March 2013.

But it wasn’t long before a row broke out. Professor David Richards of the University of Exeter, an adviser to the programme, told the Guardian that the government was misrepresenting the financial commitment “to shore up their very poor opinion poll ratings,” and was promptly removed from his post. The money announced by Mr Clegg, he said, was not ringfenced.

The government’s document, Talking Therapies: a Four Year Plan of Action, makes clear that Professor Richards was right. Training and salary costs, it says, are included in the funding stream, “although they will not be ring-fenced and there may be regional differences in how this is implemented in line with local need.” The document adds, “Once trained, therapists will be funded by PCTs [primary care trusts] or their successor organisations from baseline allocations,” which had long been the case.

Experience indicates that central initiatives without ringfenced money do not always survive long. Nigel Hawkes's columns dating back to 2007 are available on bmj.com

When general practitioners are in the driving seat, of course, all this may change. They see enough depressed and anxious people to be aware that dispensing pills is not a satisfactory response. But the pressures are going to be intense, and the evidence that the IAPT programme is a cost effective use of limited money is far from bulletproof.

The impact assessment on the expansion of the programme, signed off by Mr Burstow, estimates that the cost of providing a course of treatment is £136 for mild mental health problems and £754 for moderate or severe cases. This, the assessment says, is substantially lower than the estimated costs for talking therapies before IAPT, which are quoted as £255 and £1298.

Quite where these figures come from is a bit of a mystery because they conflict with those collected by a team led by Professor Glenys Parry of the University of Sheffield, which evaluated the first two pilot sites for the programme, in Doncaster and Newham, comparing them with neighbouring services (Wakefield and Barnsley and City and Hackney). They found that IAPT treatments cost more, not less, than those provided in the neighbouring boroughs, and that it was not possible to say whether the extra costs were justified by better outcomes.

When the analysis was limited to patients who had been treated under IAPT (many of those referred do not turn up) the team found an incremental cost of £519 a patient for IAPT and a difference in gain of quality adjusted life years (QALYs) “which is nearly significant.”

The cost per QALY for this comparison was nearly £40 000, though the team makes it clear that the confidence intervals are wide and the conclusions tentative. The result—hardly encouraging—was that there was little difference between the IAPT sites and the comparator PCTs, and what differences there were in outcomes were not significant four months after treatment and had disappeared at eight months. So the service cost more and failed to deliver significant improvements, the opposite of what is claimed in the impact assessment.

The Department of Health’s supporting documents include one that makes the economic case for improvements in mental health, but Professor Parry’s study does not appear among its 90 references. Nor does it appear in the 68 references quoted in the 53 page impact assessment, which is odd because her study was published by the National Institute for Health Research under its service delivery and organisation programme. I understand the research cost £480 000, which is quite a lot of money to ignore when it produces conclusions that don’t quite fit.

On the positive side, Professor Parry’s study did find a significant increase in therapy and a reduction in use of general practitioners, at least in Doncaster, so IAPT may achieve its aim of increasing access. But another study published in July last year by the North East Public Health Observatory showed that in the first 32 IAPT sites only about half of the patients referred had even an initial assessment, and of those who completed their care, more than a third had attended only one session.

Guidelines from the National Institute for Health and Clinical Excellence say that 6-8 sessions are needed for mild depression and 16-20 for more serious cases in which high intensity treatment is needed. Only 1.4% of patients who need high intensity treatment in this study met the NICE guideline, which raises questions over the economic calculations in the impact assessment, based as they are on 80% of IAPT patients completing treatment. The aim of IAPT is admirable and necessary. But the risk it faces is plain. In devolutionary times, it may just prove one centrally mandated programme too many.

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Competing interests: Nigel Hawkes is a member of the advisory board of Ultrasys, a company that provides a computerised form of cognitive behavioural therapy, “Beating the Blues,” approved by the National Institute for Health and Clinical Excellence in 2006.

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