



Improving access to psychological therapies and older people: Findings from the Eastern Region



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ABSTRACT

Background: Evaluations of the Improving Access to Psychological Therapies (IAPT) scheme have not yet focused on minority subgroups. This paper aims to evaluate accessibility, waiting times and clinical outcomes of IAPT for older adults.

Methods: All referrals from six Primary Care Trusts (PCT) in the East of England were used in this analysis. During each session, the therapist recorded information on anxiety symptoms using the Generalised Anxiety Disorder Questionnaire (GAD-7) and depressive symptoms with the Patient Health Questionnaire (PHQ-9). Waiting times, type of referrals and reliable recovery rates were investigated.

Results: Older adults accounted for only 4% of all the IAPT referrals made between September 2008 and July 2010 in the Eastern Region. Waiting times for both IAPT assessment and treatment were slightly lower for older adult. In all centres, reliable recovery rates were higher in older adults compared to younger adults post-treatment, however these differences were not significant, with the exception of a difference in anxiety scores ($\chi^2(1) = 18.6, p < 0.001$). In multivariate analyses, being an older adult was associated with recovery for depression (OR = 1.30, 95% CI 1.10–1.53), anxiety (OR = 1.42, 95% CI 1.21–1.66), and overall recovery (OR = 1.31, 95% CI 1.10–1.54) after adjustment for gender, PCT region, baseline score, maximum treatment step during treatment, dropping out, and number of sessions.

Conclusions: The IAPT services were shown to be beneficial to older patients, however, access to these services in later life has been lower than expected. The service pathway for older populations needs to be better researched in order to eliminate possible obstacles in accessing services.

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Introduction

Anxiety and depression are two highly prevalent mental conditions in adults. Both conditions have been shown to be leading contributors to disability (Bijl & Ravelli, 2000; Prina, Ferri, Guerra, Brayne, & Prince, 2011a), are associated with an increased risk of other physical illnesses (Knol et al., 2006; Wulsin & Singal, 2003), and have a major impact on quality of life (Beard, Weisberg, & Keller, 2010; Rapaport, Clary, Fayyad, & Endicott, 2005). Anxiety and depression remain common throughout the lifetime with

estimates among older people varying from 13.5% for depression (Beekman, Copeland, & Prince, 1999) to 1–15% for anxiety disorders (Bryant, Jackson, & Ames, 2008; Prina, Ferri, Guerra, Brayne, & Prince, 2011b). The type of treatment offered for common mental disorders is similar for both younger and older adults, with pharmacological and psychological interventions being the most common. Psychological interventions have been used successfully for the treatment of anxiety disorders in older age, as demonstrated by the large number of meta-analyses that have shown the benefits of interventions over control conditions (Goncalves & Byrne, 2012; Hendriks, Oude Voshaar, Keijsers, Hoogduin, & van Balkom, 2008). Psychological therapies have also been shown to be effective in the treatment of depression in later life (Krishna et al., 2011; Pinguart, Duberstein, & Lyness, 2007). A recent report highlighted that psychological therapies are equally effective in the treatment

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of depression in younger and older adults (Cuijpers, van Straten, Smit, & Andersson, 2009). This may not be the same for anxiety, with a meta-analysis of Cognitive Behavioural Therapy (CBT) showing a lower efficacy in older versus working-age adults (Gould, Coulson, & Howard, 2012). However, the disparity in findings may have been driven by methodological differences (Gould et al., 2012); these treatments may be equally effective across the life spectrum.

Partly based on the effectiveness of psychological therapies for the treatment of common mental disorders, a large-scale scheme for Improving Access to Psychological Therapies (IAPT) for people suffering with mild or moderate anxiety and depression was announced within the English National Health Service in October 2007 and piloted in Doncaster and Newham in Greater London. The IAPT service is based on a stepped-care model, as recommended by the National Institute for Health and Clinical Excellence (NICE) (NICE, 2011). Step 2 (“treatment of mild depression in primary care”) and Step 3 (“treatment of moderate to severe depression in primary care”) are the main focus of the IAPT services. Low intensity interventions are delivered during Step 2 by a mix of workers with a wide range of backgrounds who have trained as Psychological Wellbeing Practitioners (PWP). The types of therapies available in Step 2 can be delivered by either face-to-face contact or telephone support and include bibliotherapy, behavioural activation, guided cognitive behavioural self-help, guided self-directed exposure therapy, and computerised CBT. Step 3 is used mostly for moderate to severe depression and is generally delivered by CBT competent professionals. Individual CBT, group CBT, therapy sessions with guided self-help and medication advice can all be during this step.

A specific aim of the IAPT programme was to relieve the stress and financial costs associated with mood disorders. These were estimated at approximately £ 150 billion alone for depression in 2009/2010 (The Centre for Economic Performance’s Mental Health Policy Group, 2006) across the country. The IAPT programme is based on the concept that an improvement in mental health across the UK would result in economic gains related to increased productivity and re-employment of those individuals unable to work due to mental illnesses (Clark et al., 2009). Layard (2006) claimed “the cost to the government would be fully covered by the savings in incapacity benefits and extra taxes that result from more people being able to work”. The cost-benefit assumption that was made at the inception of IAPT is probably more applicable to working-age adults rather than to older adults, a group of people unlikely to re-enter the work market. However, under the Equality Act 2010, public bodies are not allowed to discriminate access to services on the basis of age. IAPT services are no exception.

The economic argument however may also be valid for older adults. Indirect cost savings related to hospitals and carers could be used to argue for better recognition and treatment of common mental disorders in older age. A recent paper has shown that older adults with depression have much higher hospital care costs than people without depression (Prina et al., 2014). Moreover, many older adults are also involved in other ways besides paid employment, for example in voluntary roles or in supporting family members (e.g. with child care, enabling parents to work) (Royal Voluntary Service (WRVS), 2011). It is therefore important that older adults are able to access services, not only on moral grounds, but also on quality of life grounds and potential cost savings to health services, and more broadly to society.

In this paper, we aim to explore possible differences in referrals and waiting times to access IAPT services between younger and older adults, using data from Primary Care Trusts (PCTs) in the East of England. Clinical outcomes and differences in clinical recoveries are also explored.

Methods

Data extraction

The study aimed to include all the referrals to IAPT services in the East of England between September 2008 and July 2010. Five of the 12 Primary Care Trusts (PCTs) had been commissioning the service for less than 12 months, so data were used only from the remaining seven PCTs with stable services by September 2008. One further PCT was removed from the analyses as it did not include any adults over the age of 65. The remaining six PCTs were: Bedfordshire, Mid-Essex, North-East Essex, North-East Hertfordshire, Suffolk, and West Hertfordshire. Each PCT was anonymised and given a corresponding letter from A to F, using a similar approach as the one used in a previous paper (Hammond et al., 2012).

Measurements

During each session, therapists uploaded information onto the Patient Case Management Information System (PC-MIS), the routine clinical data system used within IAPT. The information captured at each session contributed to the IAPT minimum data set. This included information on socio-demographics, attendance, source and date of referral, date of appointment, primary diagnosis and treatment outcomes.

Symptom severity was assessed using two different scales. Anxiety symptoms were measured using the Generalised Anxiety Disorder Scale (GAD-7). This is a seven-item scale, with each item scored from zero (“Not at all bothered by the problem”) to three (“Bothered nearly every day”). The cumulative score on this scale can range from 0 to 21. A score of eight or higher on this scale has been shown to correspond to a clinical diagnosis of anxiety (Spitzer, Kroenke, Williams, & Lowe, 2006).

The Patient Health Questionnaire Depression scale (PHQ-9), a nine-item scale, was used to assess symptoms of depression. The item scoring for this scale is similar to the GAD-7, with responses ranging from zero to three. The sum score can range from 0 to 27. A score of 10 has been used as a diagnostic threshold for clinical depression (Lowe, Kroenke, Herzog, & Grafe, 2004).

Information on socio-demographic data was also included in the IAPT minimum data set and included gender, age and ethnicity. Ethnicity grouped into White, Mixed, Asian, Black, and ‘Chinese or other’.

Statistical analysis

The database used for our analyses included every adult referred to IAPT who had at least two scheduled sessions, and for whom the GAD-7 and the PHQ-9 scales had been completed.

For this study, we subdivided the sample in two age groups: those aged between 18 and 65, and those over 65. We compared and contrasted clinical indicator scores (PHQ-9 and GAD-7) and outcomes (waiting times, source of referrals, recovery).

Source of referrals and waiting times compared between the two groups using Chi-Square tests of independence. Both time to first assessment and time to first treatment were calculated using the referral date as time zero. Mean and median times were calculated with their respective standard deviations (SDs) and interquartile ranges (IRQs). Mann–Whitney *U* tests were used to compare median times between the two different populations. The sources of referrals were grouped in the following categories: general practitioners, other clinical specialties, health visitors, self-referrals, others.

Because the sampling criteria of two or more completed sessions may have distorted true dropout rates, we included all the

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