Improving Access to Psychological Therapies
Services Equity Audit

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Document Overview: A health equity audit (HEA) is a tool which is used to identify and address inequalities, looking at how resources are distributed in relation to the needs of different groups. This audit is looking at the IAPT (Improving Access to Psychological Therapies) services in Salford. These services have been introduced to help support people with common mental health problems such as depression and anxiety. The services are designed to offer a level of support that gets the best results through self-help and supporting people back to enjoying life and getting back to work.

The objective of this equity audit is to review access to IAPT services in Salford and explore whether provision and access are appropriate for the areas/populations of need.

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</tbody>
</table>
Contents

1. Introduction .............................................................................................................................. 7
   1.1 Objective ............................................................................................................................ 7
   1.2 Scope and Exclusions ......................................................................................................... 7
2. Health Equity Audit .................................................................................................................. 7
3. Methods .................................................................................................................................. 8
4. Background: Understanding mental health needs ..................................................................... 8
   4.1 Depression .......................................................................................................................... 8
   4.2 Anxiety ............................................................................................................................... 9
   4.3 National prevalence of depression and anxiety ................................................................ 9
   4.4 Mental Health Needs in Salford ...................................................................................... 10
   4.5 Differences in depression and anxiety experienced by different groups ...................... 11
      4.5.1 Gender ....................................................................................................................... 11
      4.5.2 Ethnicity ...................................................................................................................... 12
      4.5.3 Older people ............................................................................................................... 12
      4.5.4 Deprivation .................................................................................................................. 12
      4.5.5 Family and Social Network Factors .......................................................................... 14
5. IAPT: Policy Context and Local Provision .............................................................................. 15
   5.1 National Institute for Clinical Excellence (NICE) Guidance ............................................. 15
   5.2 The National Mental Health Strategy ............................................................................... 15
   5.3 Talking Therapies- A Four Year Plan of Action ............................................................... 16
   5.4 NHS Operating Framework ............................................................................................. 16
   5.5 Public Health Outcomes Framework ............................................................................... 17
   5.6 IAPT Services in Salford ................................................................................................. 17
   5.7 Low intensity IAPT service in Salford ............................................................................. 18
6. RESULTS: Referrals to Low Intensity Service ....................................................................... 19
   6.1 Acceptance of referrals and treatment received ............................................................... 21
   6.2 Waiting times ................................................................................................................... 22
   6.3 Outcomes of treatment ..................................................................................................... 23
   6.4 The effect of deprivation ................................................................................................. 24
7. Recommendations .................................................................................................................... 25
## List of Tables, Graphs, Figures

<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1</td>
<td>Percentage of referrals to low intensity IAPT service, by gender for each age group 2010/11</td>
</tr>
<tr>
<td>Table 2</td>
<td>Percentage breakdown of ethnicity in Salford in 2009, and for referrals to Six Degrees, 2010/11</td>
</tr>
<tr>
<td>Graph 1</td>
<td>Estimated rates (sufferers per 1000 population aged 16-74) for any neurotic disorder, by PCT</td>
</tr>
<tr>
<td>Graph 2</td>
<td>Estimated rates (sufferers per 1000 population aged 16-74) six types of neurotic disorder, in Salford</td>
</tr>
<tr>
<td>Graph 3</td>
<td>Rate of mental health outpatient and community attendances, and IMD2007 average scores, for the wards in Salford.</td>
</tr>
<tr>
<td>Graph 4</td>
<td>Age and gender profile of referrals to the low intensity IAPT service 2010/11</td>
</tr>
<tr>
<td>Graph 5</td>
<td>Ethnicity data of referrals to low intensity IAPT service, 2010/11</td>
</tr>
<tr>
<td>Graph 6</td>
<td>Proportion of referrals of women accepted by the low intensity IAPT service, by age group, 2010/11</td>
</tr>
<tr>
<td>Graph 7</td>
<td>Proportion of referrals of men accepted by the low intensity IAPT service, by age group, 2010/11</td>
</tr>
<tr>
<td>Graph 8</td>
<td>Change in PHQ-9 score, by pre-treatment score, for service users of low intensity IAPT service, 2010/11</td>
</tr>
<tr>
<td>Graph 9</td>
<td>Change in GAD-7 score, by pre-treatment score, for service users of low intensity IAPT service, 2010/11</td>
</tr>
<tr>
<td>Figure 1</td>
<td>Levels of depression and anxiety in adults aged 16 years and over, by ward in Salford.</td>
</tr>
<tr>
<td>Figure 2</td>
<td>The stepped care model for treatment of depression.</td>
</tr>
<tr>
<td>Figure 3</td>
<td>MOSAIC Profile of service users accessing IAPT service in Salford 2010/11.</td>
</tr>
</tbody>
</table>
Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>In Full</th>
</tr>
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<td>APMS</td>
<td>Adult Psychiatric Morbidity Survey</td>
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<td>CMD</td>
<td>Common Mental Disorder</td>
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<td>GAD</td>
<td>Generalised Anxiety Disorder</td>
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<td>HEA</td>
<td>Health Equity Audit</td>
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<td>HNA</td>
<td>Health Needs Assessment</td>
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<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
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<td>MWNA</td>
<td>Mental Wellbeing Needs Assessment</td>
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<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
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<td>OCD</td>
<td>Obsessive Compulsive Disorder</td>
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1. Introduction

Increasing Access to Psychological Therapies (IAPT) services are aimed at supporting people who are experiencing depression and/or anxiety. The services are designed to offer a level of support that gets the best results through self-help and supporting people back to enjoying life and getting back to work. Improving Access to Psychological services (IAPT) have been available in Salford since 2008, delivered through a range of providers. There is national and local commitment to continue providing these services.

A health equity audit (HEA) is a tool which is used to identify and address inequalities, looking at how resources are distributed in relation to the needs of different groups. This audit is looking at the IAPT (Improving Access to Psychological Therapies) services in Salford, to understand if our services are seeing the clients who we understand to most need these services.

Poor mental health is linked with deprivation, and the Salford Mental Wellbeing Needs Assessment (MWNA) indicated that this correlation is the case for Salford residents. The MWNA demonstrated that approximately 5% of the population of Salford have extreme anxiety or depression. This HEA will review the IAPT services provided in Salford, and look at the referrals, treatment and results to consider if these are appropriate for our levels of need in relation to deprivation, age, gender and ethnicity.

1.1 Objective
To review access to IAPT services in Salford and explore whether provision and access are appropriate for the areas/populations of need.

1.2 Scope and Exclusions
Included:
- The audit is to include providers of IAPT services within Salford for Salford residents.

Excluded:
- The audit should note whether Salford residents are referred outside Salford but it is not in its remit to audit those services.

2. Health Equity Audit

A health equity audit (HEA) is a tool used to identify and address inequalities, focusing on how fairly resources are distributed in relation to the health needs of different groups. HEA enables a systematic review of inequities in ill-health or in access to effective services, in this case IAPT services. Equities refer to situations where level of access is truly related to level of need. HEA specifically investigates issues around access to healthcare according to epidemiology and demographic group.

HEA identifies how fairly services or other resources are distributed in relation to the health needs of different groups and areas and the priority action to provide services relative to need. The overall aim is not to distribute resources equally but rather, relative to health need. This process assists the planning and decision-making processes of organisations. It determines

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whether the distribution of health outcomes, healthcare or the determinants of health are inequitable or unrelated to need and action is then taken to remedy and monitor progress.  

Health equity audit is a vital part of the planning process for tackling health inequalities. It can identify actions required to make services more equitable (thereby reducing inequalities) to be incorporated into local plans, services and practice.

### 3. Methods

In order to understand the needs of the Salford population in relation to the IAPT services, the national picture was established from the literature available, and then local information from the Mental Wellbeing Needs Assessment (MWNA) was reviewed.

Much of the information about the national picture is derived from the Adult Psychiatric Morbidity Survey (APMS) 2007. This is the third survey of its kind, and uses a two-phase approach of interviews to provide data on the prevalence of both treated and untreated psychiatric disorder in the English adult population (aged 16 and over).

Understanding the need then enables us to review the profile of those accessing the services available and to compare these. Understanding the differences enables recommendations to be made about future commissioning of these services to ensure that the services are most appropriately meeting the needs of the Salford population.

Local service data was provided from the low and high intensity services, which form the IAPT service package in Salford. The data was requested from April 2010 – March 2011 for all services to understand the picture from the most recent complete financial year.

### 4. Background: Understanding mental health needs

Mental health problems are among the most common health conditions, directly affecting about a quarter of the population in any one year. Depression and anxiety are the most widespread conditions; only a small percentage of people experience more severe mental illnesses.

Common mental disorders (CMDs), are mental conditions that cause marked emotional distress and interfere with daily function, though they do not usually affect insight or cognition. CMDs comprise different types of depression and anxiety. Symptoms of depression and anxiety frequently co-exist, demonstrated for example by high proportions of individuals meeting the criteria for more than one CMD or for mixed anxiety and depressive disorder.

#### 4.1 Depression

The term ‘depression’ is used to describe a range of moods, ranging from low spirits to more severe mood problems that interfere with everyday life. Depression can affect many different people in very different way, and there can be physical symptoms as well as emotional ones.

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Symptoms may include a loss of interest and pleasure, excessive feelings of worthlessness and guilt, hopelessness, morbid and suicidal thoughts, and weight loss or weight gain. A depressive episode is diagnosed if at least two out of three core symptoms have been experienced for most of the day, nearly every day, for at least two weeks. These core symptoms are:

- Low mood
- Fatigue or lack of energy
- Lack of interest or enjoyment in life

A depressive episode may be classed as mild, moderate or severe, depending on the number and intensity of associated symptoms, such as sleep disturbance, appetite and weight change, anxiety, poor concentration, irritability and suicidal thoughts.  

4.2 Anxiety

Anxiety is a normal response to threat or danger and part of the usual human experience, but it can become a mental health problem if the response is exaggerated, lasts more than three weeks and interferes with daily life. Anxiety is characterised by worry and agitation, often accompanied by physical symptoms such as rapid breathing and a fast heartbeat or hot and cold sweats.

Anxiety disorders include generalised anxiety disorder (GAD), panic disorder, phobias, and obsessive and compulsive disorder (OCD).

Generalised anxiety disorder (GAD) is diagnosed after a person has on most days for at least six months experienced extreme tension (increased fatigue, trembling, restlessness, and muscle tension), worry, and feelings of apprehension about everyday problems. The person is anxious in most situations, and there is no particular trigger for anxiety.

People who experience anxiety usually have symptoms that fit into more than one category of anxiety disorder, and are usually diagnosed with at least one other mental disorder, most commonly depression.

‘Stress’ is not considered a mental health problem in its own right, but long-term stress may be associated with anxiety or depression.

4.3 National prevalence of depression and anxiety

The national picture is as follows:

- The prevalence of a common mental disorder (CMD) for adults in the UK is 16.2%
- More than half of adults with a CMD have mixed anxiety and depressive disorder (9.0%).
- General anxiety disorder is the next most common condition (4.4%), followed by depressive episode (2.3%).
- Depression tends to recur in most people. More than half of people who have one episode of depression will have another, while those who have a second episode have a

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further relapse risk of 70%. After a third episode, the relapse risk is 90%. For about 1 in 5 people, the condition is chronic.\textsuperscript{11}

4.4 Mental Health Needs in Salford

The Mental Wellbeing Health Needs Assessment completed in Salford established that around 36,000 adults (20\% of those aged 16 and over) living in Salford may have a mental health need and of these, 7,900 adults (21\% of the total) are likely to have extreme anxiety or depression. This is approximately 5\% of the adult population of Salford.\textsuperscript{12}

Further information about the needs in Salford can be derived from the APMS data being applied to our local population. This has been done for all PCTs in England and demonstrates that NHS Salford has the fourth highest rate sufferers of neurotic disorders of any other primary care trust.\textsuperscript{13}

Graph 1 shows estimated rates (sufferers per 1000 population aged 16-74) for any neurotic disorder, by PCT. NHS Salford is shown in red.

Furthermore, the breakdown of these neurotic disorders can be considered for Salford, and this enable us to see the most common types of neurotic disorder for the NHS Salford population. From graph 2, below, it is clear that mixed anxiety and depression is the most common of these


\textsuperscript{12} NHS Salford (2010). Salford Mental Wellbeing Needs Assessment.

neurotic disorders in Salford at a rate of 124/1,000. This equates to over 19,800 cases in the NHS Salford population.¹⁴

**Graph 2 shows estimated rates (sufferers per 1,000 population aged 16-74) six types of neurotic disorder, in Salford.**

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**4.5 Differences in depression and anxiety experienced by different groups**

The national picture described above represents the average rates across the population as a whole, however there are important differences in the way that depression and anxiety is experienced by different groups. Evidence suggests differences in the rates of mental health problems for: gender; ethnicity; age; deprivation; disability; homelessness; prisoners; carers; refugees.¹⁵ The evidence supporting differences experienced by different groups, particularly in relation to depression and anxiety, is described.

**4.5.1 Gender**

Women are more likely to have been treated for a mental health problem than men (29% women compared with 17% men).¹⁶ Depression and anxiety are more common in women than men¹⁷. 1 in 4 women will require treatment for depression at some time, compared with 1 in 10

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men.\textsuperscript{18} The reasons for this are unclear, but are thought to be due to both social and biological factors.

\subsection*{4.5.2 Ethnicity}
In general, rates of mental health problems are thought to be higher in minority ethnic groups in the UK than in the white population, but they are less likely to have their mental health problems detected by a GP. Depression in ethnic minority groups has been found to be up to 60\% higher than in the white population.\textsuperscript{19} The Salford mental health HNA found that ethnicity data is not generally recorded making it difficult to determine service attendance across cultural groups.

\subsection*{4.5.3 Older people}
Older people are less likely to have a common mental disorder, excluding depression, than other sections of the British population. 10.2\% of those aged 65-69 and 9.4\% of those aged 70-74 have a common mental disorder, compared with 16.4\% of the general population.

Nationally depression affects 1 in 5 people over the age of 65 living in the community and 2 in 5 living in care homes. However, it is likely that only a small proportion of older people with depression are in contact with their GP or mental health services. An estimated 70\% of new cases of depression in older people are related to poor physical health.\textsuperscript{20}

In Salford, the MWNA found that having some depression or anxiety increased with age. Rates of depression in those over 40 years are two times higher than those aged 16-24 years.

\subsection*{4.5.4 Deprivation}
Having a low income, being unemployed, living in poor housing, low levels of education and lower social class (partly skilled people or individuals with no skills) are all associated with a greater risk of experiencing a mental health problem, with the poorest fifth of adults having double the risk of experiencing a mental health problem as those on average incomes.\textsuperscript{21} Financial problems can be both a cause and a consequence of mental health problems. People with mental health problems are three times as likely to be in debt as the general population and more than twice as likely to have problems managing money. People without a degree are almost twice as likely to experience depression as those with a degree.\textsuperscript{22}

Deprivation contributes to a greater burden of mental health problems than would be found in more affluent areas. Material deprivation is consistently associated with higher prevalence of mental health problems throughout the lifespan and impacts on mental wellbeing through what has been described as a 'cycle of invisible barriers': poverty of hope; self worth and aspirations. The links between poverty, social deprivation, and mental health are well established in public health literature and research.\textsuperscript{23}

\textsuperscript{23} Mental Health Foundation (2007). The Fundamental Facts: The latest facts and figures on mental health. Mental Health Foundation.
The economic downturn has brought into sharper focus the negative impact on mental wellbeing of: debt, unemployment, fear of unemployment, homelessness and the fear of repossession all of these in an economic climate that is likely to get worse for those on lower income who have fewer qualifications and living in areas of high economic deprivation.

Salford is the 15th most deprived Local Authority area in England and the second most deprived area in Greater Manchester. Salford also has some of the highest levels of mental ill health.

The national picture shows that in the most deprived fifth of areas, 1 in 20 men and 1 in 16 women say they have extreme anxiety or depression while 1 in 6 men and 1 in 5 women have moderate anxiety or depression.

The estimated gradient of anxiety and depression across wards in Salford increases as deprivation increases. The gradient is steep and suggests that the need for support is much greater in deprived areas.

**Figure 1: Levels of depression and anxiety in adults aged 16 years and over, by ward in Salford.**

The gradient for anxiety and depression across wards in Salford increases more sharply as deprivation increases indicating that support from the mental wellbeing services needs to be greater in most deprived wards than those less deprived. However, four wards with higher deprivation measures have slightly lower than expected anxiety and depression: these are Winton, Ordsall, Blackfriars and Pendleton.24

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When considering those people who are accessing the treatment services in Salford, some wards in Salford show lower than expected numbers of people treated by mental health teams than would be expected from their level of deprivation: these wards are Kersal, Irwell Riverside, Little Hulton and Ordsall. There may be a genuinely lower level of need or this may reflect a gap in services.

Graph 3 shows the rate of mental health outpatient and community attendances, and IMD2007 average scores, for the wards in Salford. (Increasing deprivation left to right).

On the other hand, Eccles Ward appears to have more than expected numbers of people in contact with mental health teams than expected when comparing the level of deprivation with other wards in Salford. These services include support for a range of mental health needs, in addition to depression and anxiety.

4.5.5 Family and Social Network Factors
Social isolation is also a significant risk factor for mental health problems. One in five (20%) of people with common mental health problems live alone compared to 16% of the overall population. A person with a severe mental health problem is four times more likely than average to have no close friends.

Low levels of social support can reduce the likelihood of recovery from mental health conditions. In one study 54% of women and 51% of men with mental health problems and good social support recovered over an 18 month period, compared with 35% of women and 36% of men

with a severe lack of social support. Furthermore, Singleton reports that people with a common mental health problem are twice as likely to be separated or divorced as their ‘mental healthy’ counterparts (14% compared with 7%) and are more than twice as likely to be single parents as those without a mental health problem (9% compared with 4%).

Family history is also a risk factor for poor mental health. Between a third and two-thirds of children whose parents have mental health problems will develop problems either in childhood or adult life. Children of depressed parents have a 50% risk of developing depression themselves before the age of 20.

5. IAPT: Policy Context and Local Provision

There are a number of policy documents that guide provision of mental health support services, including IAPT. These are summarised below.

5.1 National Institute for Clinical Excellence (NICE) Guidance
Increasing Access to Psychological Therapies is a national programme and has one principal aim – to help Primary Care Trusts (PCTs) implement National Institute for Clinical Excellence (NICE) guidelines for people experiencing depression and anxiety disorders.

The programme is led nationally by the Department of Health and is designed to develop the range of psychological therapies to address the needs of their populations, especially increasing the availability for those people experiencing common mental health problems.

5.2 The National Mental Health Strategy
The national mental health strategy, ‘No health without mental health: a cross-government mental health outcomes strategy for people of all ages’ (2011) is guided by six objectives:

1. More people will have good mental health. More people of all ages and backgrounds will have better well-being and good mental health. Fewer people will develop mental health problems – by starting well, developing well, working well, living well and ageing well.
2. More people with mental health problems will recover. More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.
3. More people with mental health problems will have good physical health. Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health.
4. More people will have a positive experience of care and support. Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and

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approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people’s human rights are protected.

5. Fewer people will suffer avoidable harm. People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service.

6. Fewer people will experience stigma and discrimination. Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease.

The national strategy establishes a family and generational focus to the prevention of mental health ill health, reduction of stigma and barriers to people seeking early treatment, early intervention and responses to socio-economic factors that impede good mental health including employment, accommodation and substance misuse.

5.3 Talking Therapies- A Four Year Plan of Action

‘Talking Therapies: A Four Year Plan of Action’ is the supporting guidance to implementing the roll out of IAPT services, as set out in the national strategy ‘No health without mental health’.

The action plan set out the extended roll out, indicating how more training, improving quality and extending the scope of the IAPT programme will be achieved by 2015.

This plan highlights the importance of auditing the services, and understanding the local needs and demand. The plan states that some groups may have higher prevalence of anxiety disorders and depression than others, such as carers, victims of crime, the homeless, offenders, addicts, military veterans and people with long-term physical conditions. Other groups may have proportionately lower levels of identification despite high levels of need, such as people who are gay, lesbian or bisexual. ‘Talking Therapies’ calls for services to take the needs of all these groups into account alongside those with the legally protected characteristics of age, race, religion or belief, sex, sexual orientation, disability, marriage and civil partnership, pregnancy and maternity, or gender reassignment.

5.4 NHS Operating Framework

NHS Operating Framework 2011 stated the Government’s intention to maintain and also extend the IAPT programme to target specific groups including: older people; children and young people; people with severe and enduring mental illness; and people with co-morbid mental and physical health long-term conditions.

National funding for the IAPT programme was confirmed, continuing until 2014/2015. Additionally, The Operating Framework also emphasised the importance of service user involvement, and monitoring quality and efficiency. Audit is therefore a key component of monitoring and improving services to ensure that the services meet the needs of the local population. Implementing changes where required to improve client experience, quality of service and effectiveness of interventions.

The NHS Operating Framework 2012/13 also supports the continued commitment to increasing access to psychological therapies services, aiming to meet at least 15% of disorder prevalence, with a recovery rate of at least 50 per cent in fully established services. The Operating Framework states that for 2012/13 this will mean increased access for black and minority ethnic

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groups and older people, and increased availability of psychological therapies for people with severe mental illness and long term health problems.  

5.5 Public Health Outcomes Framework
The importance of reducing the prevalence of common mental health problems, and for improving outcomes for those suffering with these conditions is highlighted in the inclusion of key indicators in the Public Health Outcomes Framework. The framework is the set of indicators that are monitored by the Department of Health to enable progress to be scrutinising on the key objectives of improving healthy life expectancy and reducing health inequalities.

Some of the most relevant indicators included are:
- People with mental illness or disability in settled accommodation
- People in prison with a mental illness or disability (placeholder)
- Employment for those with mental illness or significant mental illness (placeholder)
- Self reported wellbeing

5.6 IAPT Services in Salford
IAPT services were introduced in Salford in 2008 to ensure that people with common mental health problems are supported and referred to the most appropriate services for their experience of common mental health problems such as anxiety and depression. IAPT services are designed to offer a level of support that gets the best results and helps people to help themselves, supporting them, by managing their condition, to get back to enjoying life and engaging with work or daily activities. People’s experiences of anxiety and depression often differ and therefore various levels of support may be needed guided by the client.

Since October 2008, people in Salford have been able to access talking therapies for anxiety and depression through their GPs. The IAPT programme has employed 26 additional therapists to treat, in the first year, 3,300 patients, with an expectation that a minimum of 50% of people using the service making a recovery.

To address the mental health needs of people in Salford there are three elements to Psychological Therapies commissioned by Salford Primary Care. All three services provide a level of emotional support to people. The services provide different levels of support, in the categories:

1. High Intensity. This has two sub-components IAPT Service Step 3 and Step 4 Psychology Services; these are provided via Greater Manchester West NHS Foundation Trust.
2. Low Intensity IAPT Service. This is provided by Six Degrees Social Enterprise (formerly a PCT Provider Service up until August 1st 2011). (This service is the focus of this audit)
3. Computerised CBT Service (cCBT). This offers four sessions per week provided across the city. The provider is a charity known as ‘Self Help Services’.

All of these services underpin the objectives of the national mental health strategy, and help to keep Salford residents in the best possible mental health. These services are in line with the NICE guidance of a stepped care model below.

5.7 Low intensity IAPT service in Salford

The step 2 services in Salford are provided by Six Degrees (a social enterprise organisation). A team of Psychological Wellbeing Practitioners assess the clients’ mental health needs and work with the client to develop personalised, time-limited treatment plans, which guide the support and interventions provided. Their work is supervised by a group of expert practitioners including a consultant psychiatrist, a clinical psychologist, and a GP with a Special Interest (Mental Health).

For the majority of referrals GPs will be the primary referrer but the service will also accept referrals from primary care nurses/advanced nurse practitioners, health visitors, district nurses, and self-referrals will also be accepted. For all referrals other than those from the GP, the person’s GP will be contacted to discuss the referral.

The service is open to any person registered to an NHS Salford General Practitioner. The majority are likely to live within the City of Salford boundaries but not all. Those resident in other areas but registered with a Salford GP will have the same access rights to Salford services.

There may also be some travelling or homeless people who are resident for short periods of time, that are not registered to any GP, who may be referred to the service.

The service is primarily targeted at clients with common mental health problems of mild to moderate severity. Clients under the age of 16 should be referred to Children’s and Adolescents Mental Health Service, but there is no upper age limit for the IAPT service.

Patients always remain the primary responsibility of their GP and all work undertaken by the service will be monitored by them and undertaken on their behalf. The basis for a referral is:

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**Figure 2: The stepped-care model for treatment of depression**

<table>
<thead>
<tr>
<th>Focus of the intervention</th>
<th>Nature of the intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STEP 1:</strong> All known and suspected presentations of depression</td>
<td>Assessment, support, psychoeducation, active monitoring and referral for further assessment and interventions</td>
</tr>
<tr>
<td><strong>STEP 2:</strong> Persistent subthreshold depressive symptoms; mild to moderate depression</td>
<td>Low-intensity psychosocial interventions, psychological interventions, medication and referral for further assessment and interventions</td>
</tr>
<tr>
<td><strong>STEP 3:</strong> Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression</td>
<td>Medication, high-intensity psychological interventions, combined treatments, collaborative care and referral for further assessment and interventions</td>
</tr>
<tr>
<td><strong>STEP 4:</strong> Severe and complex depression; risk to life; severe self-neglect</td>
<td>Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multiprofessional and inpatient care</td>
</tr>
</tbody>
</table>

- Has a common mental health problem (as indicated by validated assessment tool PHQ-0 and/or GAD-7)
- Is ‘safe to be seen’ i.e. at low / intermediate risk to themselves or others
- Is likely to benefit from the service

People with co-existing morbidity (such as drug misuse, alcohol misuse) or who have learning disabilities to an extent that primary mental health services are deemed appropriate, will be accepted into the service and the service will work with them in partnership with other support services, as with all other service users.

After an initial assessment, which includes the use of the PHQ-9 and the GAD-7 tools, a care plan detailing the guided self-help material and brief intervention work is described for each client; progress against the care plan is monitored at the weekly supervision sessions.

### 6. RESULTS: Referrals to Low Intensity Service

Between 1\textsuperscript{st} April 2010 and 31\textsuperscript{st} March 2011, there were 4689 referrals made to this service. The breakdown by gender and age group is shown in Graph 4 below.

**Graph 4 shows the age and gender profile of referrals to the low intensity IAPT service 2010/11**

There are more women than men accessing this service. This is in line with the demand we would expect, as more women are treated for mental health problems. Table 1 shows the ratio of women to men at the different age groups.
Table 1: Percentage of referrals to low intensity IAPT service, by gender for each age group 2010/11

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Gender</th>
<th>Gender Ratio (F/M)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>15-24</td>
<td>643</td>
<td>311</td>
</tr>
<tr>
<td>25-34</td>
<td>731</td>
<td>520</td>
</tr>
<tr>
<td>35-44</td>
<td>684</td>
<td>434</td>
</tr>
<tr>
<td>45-54</td>
<td>468</td>
<td>314</td>
</tr>
<tr>
<td>55-64</td>
<td>261</td>
<td>140</td>
</tr>
<tr>
<td>65-74</td>
<td>93</td>
<td>40</td>
</tr>
<tr>
<td>75+</td>
<td>23</td>
<td>9</td>
</tr>
<tr>
<td>All ages</td>
<td>2903</td>
<td>1768</td>
</tr>
</tbody>
</table>

In summary, the number of men being seen by the service is proportionally higher in the 25-64 year groups, and the number of women being seen is higher in both the younger and older age groups. In the older age groups this may be due to the life expectancy differences between men and women, as there are proportionally fewer men, and these men may be accessing treatment for mental health problems through other services including dementia services or social care services, reducing the demand on this IAPT service. They also may not be accessing services, indicating an unmet and unknown level of need.

For the younger groups, the higher proportion of women accessing the service may be due to the stigma associated with accessing mental health services with men less likely to seek help.

The ethnicity profile of those being referred to this service is shown below in graph 5 and table 1.

**Graph 5 shows the ethnicity data of referrals to low intensity IAPT service, 2010/11**
Graph 5 shows that, where ethnicity is known, the majority of service users are white (46% where only 48% known). This is in keeping with the ethnicity profile of Salford, which is shown in table 2.

**Table 2: Percentage breakdown of ethnicity in Salford in 2009, and for referrals to Six Degrees, 2010/11**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Salford Metropolitan District</th>
<th>Six Degrees Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Persons (count)</td>
<td>225100</td>
<td>2248</td>
</tr>
<tr>
<td>% of total</td>
<td>91.7%</td>
<td>94.98%</td>
</tr>
<tr>
<td>White</td>
<td>91.7%</td>
<td>94.98%</td>
</tr>
<tr>
<td>Mixed</td>
<td>1.5%</td>
<td>0.71%</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>3.4%</td>
<td>1.65%</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>1.7%</td>
<td>1.33%</td>
</tr>
<tr>
<td>Chinese or Other Ethnic Group</td>
<td>1.7%</td>
<td>1.33%</td>
</tr>
</tbody>
</table>

Graph 5 highlights the proportion of users who do not provide their ethnicity (41%) and the proportion where ethnicity is not captured (11%). This is very high and reflects a common problem in ethnicity recording.

**6.1 Acceptance of referrals and treatment received**

Over 86% of the referrals made to the service in 2010/11 were accepted. The proportion of referrals accepted was similar for both men (84%) and women (88%).

Graph 6 shows that the proportion of referrals accepted was similar for women of all age groups. This was not the case for men, as graph 7 shows that the proportion of referrals of men accepted on to the service decreased with age, and those aged over 65 years were more than twice as likely to have their referral rejected than those under 65 (referrals not accepted ages 65+ years = 32.7%, referrals not accepted <65 years = 15.5%).

**Graph 6 shows the proportion of referrals of women accepted to the low intensity IAPT service, by age group, 2010/11**
Graph 7 shows the proportion of referrals of men accepted to the low intensity IAPT service, by age group, 2010/11

This demonstrates that over 30% of men over 65 years of age are not having their referral accepted. The reasons for this may be that there are more appropriate services for their need, or that the referral criteria have not been considered correct prior to referral. The service may wish to look in to this in more details to examine where these referrals are being made from, and understand why a greater proportion of older men are not being accepted into the service.

Whilst the number accepted in to the service was relatively high, the number then going on to receive treatment was much lower. Furthermore, there were a large number of service users who did receive treatment, despite their record showing that their referral was not accepted (561 users had at least one contact with the service despite their referral being recorded as not accepted). This is probably a coding issue.

In total, 66% of those referred to the service have one or more contact with the service, and this is comparable for men (65% referred have one or more contact) and women (66%). Across the age groups, there is variation in the proportion of those who are referred going on to be seen by the service, with those aged under 35 years being more likely to have no contact with the service, and those age over 65 years being more likely to have one or more contacts with the service.

6.2 Waiting times
Within the service specification, it is specified that from a referral being accepted, the service aims to contact the service user within two weeks (activation period), and book an initial appointment within the four subsequent weeks. This is in line with the national standards on access. In 2010/11, there was missing data for 35% of the referrals, meaning that the wait time could not be calculated for these clients. Of those that had their referral and appointment dates recorded, 81% of service users were seen within 44 days of their referral being made (44 days used to allow for non-working days, weekends). The national IAPT KPI for access is that 90% of referrals should be seen within 6 weeks. There was no difference in the number of men and women, or within the age groups, being seen within 44 days of referral.
6.3 Outcomes of treatment

The service aims to collect pre and post treatment outcome data in over 95% of patients, as required by national standards. Service users are assessed using the PHQ-9 and the GAD-7, which are validated tools for the assessment of depression (PHQ-9) and anxiety (GAD-7).

In 2010/11 91% of those having one or more contact with the service had their initial PHQ-9 score recorded. For those having 2 or more contacts with the service, this rose to 97%, and of those, 82% had both a pre and post treatment PHQ-9 score recorded. 2% of service users had neither pre- nor post-treatment PHQ-9 score recorded.

In 2010/11 90% of those having one or more contact with the service had their initial GAD-7 score recorded. For those having 2 or more contacts with the service, this rose to 97%, and of those, 81% had both a pre and post treatment GAD-7 score recorded. 3% of service users had neither pre- nor post- treatment GAD-7 score recorded.

Where PHQ-9 and GAD-7 scores are known, the outcomes of treatment are shown to be positive, with most service user demonstrating a reduction (an improvement) in their score.

Graph 8 shows the change in PHQ-9 score, by pre-treatment score, for service users of low intensity IAPT service, 2010/11
This shows that for all service users where a pre and post treatment score was recorded, half of them showed post-treatment score 50% or more better than their pre-treatment score.

The rates of improvement were higher for those presenting with higher pre-treatment scores (‘worse’ prior to starting treatment).

**Graph 9 shows the change in GAD-7 score, by pre-treatment score, for service users of low intensity IAPT service, 2010/11**

This shows that for all service users where a pre and post treatment score was recorded, nearly half of them showed post-treatment score 50% or more better than their pre-treatment score.

The rates of improvement were higher for those presenting with higher pre-treatment scores (‘worse’ prior to starting treatment).

**6.4 The effect of deprivation**

The MOSAIC social marketing analysis uses a range of deprivation measures and is an accurate system of locating deprived households across Salford.
This analysis has been used to review the services users of this IAPT service, and consider how deprivation is associated with likelihood to access this service.

**Figure 3: MOSAIC Profile of service users accessing IAPT service in Salford 2010/11**

Figure 3 shows the classifications of groups accessing this service, the rates of those groups in treatment, and the likelihood of those groups to be accessing treatment compared to the rest of the population (for Salford, and nationally). This demonstrates that the most deprived groups (household type that are shown in red), are substantially more likely to be using this service.

### 7. Recommendations

Based on this audit, the following recommendations are made to the service:

1. Improved recording of key performance indicators is required to enable future analysis and auditing of this service. Currently there are large numbers of service users where important information about ethnicity and pre- and post-treatment scores are unknown. Collection of this information is important in assessing performance.

2. The service should aim to reduce waiting times. At the time of this audit, only approximately 81% of service users were being seen within the waiting time expected as a national standard, and data on wait time was missing for 35% of users.
3. This audit demonstrates that those aged under 35 years of age, who have their referral accepted, are less likely to go on to have any contact with the service. The service should consider this in planning and marketing their service and should consider investigating the reasons for this.

4. The audit suggests that people in Eccles access the service more than is expected when taking into consideration the level of deprivation. The service should assess the referral process and criteria assessment process in place in Eccles area to ensure this is in line with the service access criteria.

5. The audit suggests a lower up take of the service in the wards of Kersal, Irwell Riverside, Little Hulton and Ordsall than is expected when taking into consideration the level of deprivation in these areas. The service should seek to understand why the uptake is lower than expected, review the referral processes and develop a marketing plan based on insight and intelligence to ensure referrers and clients are aware of the service.

The next steps for this audit are recommended to be:

- Share with the JSNA executive for consideration of inclusion of the findings within the JSNA.

- Presented to the Integrated Commissioning Board for review.

- Production of an additional comprehensive Health Equity Audit, to map the entire IAPT service provision, to be completed by July 2013.