



TALKING IT OUT

Psychological Therapies in Scotland

SUMMARY

Many of us find that, when we are struggling with our mental health, it helps to talk to someone. And official health advice backs that up: people with depression should be offered a psychological therapy as well as, or instead of, antidepressants, depending on the severity of their condition¹.

In Scotland, the Government has set a target that everyone referred for a psychological therapy should begin treatment within eighteen weeks. This target was due for delivery by December 2014, but just five of the fourteen Health Boards achieved this². This compares with provision in England, where 61% of people are seen within 28 days³.

SAMH often hears from people who are experiencing mental health problems that they want a wider range of choice in the treatments they are offered, and that it can be very difficult to access psychological therapies. But the evidence base for such therapies is good: Scottish guidance recommends particular therapies, such as Cognitive Behavioural Therapy (CBT), interpersonal therapy and behavioural activation, for people with depression⁴.

We wanted to find out about people's experiences of accessing psychological therapies, so we surveyed almost 500 people in Scotland. We also made Freedom of Information requests to all Scottish Health Boards, to find out more about what type of therapies they are providing and who is receiving such therapies. Finally, we looked at the official figures for psychological therapies waiting times in Scotland and examined the alternative system of provision being piloted in England.

What do we mean by psychological therapies?

NHS Health Scotland defines Psychological Therapies as a range of interventions, based on psychological concepts and theory, which are designed to help people understand, and make changes to, their thinking, behaviour and relationships in order to relieve distress and to improve functioning⁵.

1 NICE, Depression in Adults: the treatment and management of depression in adults, 2009

2 ISD, Psychological Therapies Waiting Times, February 2016

3 HSCIC, Psychological Therapies: Annual Report England, 2013/14

4 SIGN, Non-Pharmaceutical Management of Depression in Adults, 2010

5 NHS Education for Scotland, The Matrix, A Guide to Delivering Evidence-Based Psychological Therapies in Scotland, 2011

KEY FINDINGS

- Almost half of those who had been referred for a psychological therapy had found the length of time they had to wait either very, or quite, difficult.
- Almost a fifth of people who had been referred waited between 1-3 months for treatment to begin, while over a tenth waited between 3-6 months.
- The longer people waited for treatment, the more likely it was that their mental health deteriorated while waiting.
- 38% of those who gave a view felt they did not receive enough sessions of therapy.
- Those who felt they'd received the right amount of sessions were far more likely to think that therapy had helped them.
- Respondents were clear that psychological therapies did help, both at the time and later in life. Three-quarters of those who had completed their therapy and who expressed a view said it had helped at the time, and almost two-thirds said it still helped them now.
- Almost a fifth of those who had been referred for a psychological therapy did not know what type of therapy they had received.
- Most health boards do not appear to be closely monitoring the types of psychological therapies they are providing.
- Most health boards do not appear to be monitoring equalities data about which groups are accessing psychological therapies.
- Scotland was the first country in the world in 2010 to introduce waiting times targets for psychological therapies. However, we are not tracking the outcomes of treatment, nor do we have any target for increasing the volumes of people who receive treatment.

RECOMMENDATIONS

- The Scottish Government should commission an independent inquiry into the failure of Health Boards to meet the current 18 week waiting time targets for people receiving a psychological therapy and report back its findings by May 2017.
- NHS Scotland should be supported towards an interim twelve week target, giving mental health treatment parity with treatments for other illnesses.
- The Scottish Government, with NHS Scotland, must develop a minimum data set on outcomes of psychological therapies, to allow measurement and reporting of their effectiveness.
- Where psychological therapies are time-limited, this should be based on evidence of effectiveness and not resource rationing. The reasons for time-limiting a therapy should be clearly explained to patients.
- NHS Scotland should set a target to increase the number of people receiving psychological therapies year-on-year.
- Health boards should routinely collect and evaluate equalities data on who is receiving psychological therapies.
- Health boards must ensure that patients receive clear information about the type of therapy they are receiving and the reasons for this choice.



“The team work shown between my community pharmacist, GP, CPN, support worker, psychologist, psychiatrist and myself has made all the difference. That net of communication and support has allowed a steady flow of ongoing recovery for me and no doubt/ hopefully many others. ”

POLICY BACKGROUND

In 2010, the Scottish Government set a target that people should not wait any longer than 18 weeks between being referred for a psychological therapy and starting their treatment. This target was due for completion by December 2014 and was not met: just five of the fourteen Health Boards achieved it⁶.

The types of psychological therapy which “count” towards meeting the target are set out in The Matrix, an NHS Education for Scotland guide to evidence-based psychological therapies.

In England, a programme called Increasing Access to Psychological Therapies (IAPT) was opened up to all adults in 2010. Since 2011, its work has been based on Talking Therapies: a Four-Year Plan of Action.⁷ This plan was introduced as part of No Health Without Mental Health, the mental health strategy in England. As well as measuring waiting times, the IAPT approach tracks recovery rates and economic gains in terms of people returning to work. The programme reports recovery rates in excess of 45% and an expected net financial benefit of £4,640 million by the end of 2016/17.⁸

IAPT also aims to provide access for “at least 15% of the adult population in need to high-quality, evidence-based psychological therapies capable of delivering recovery rates of at least 50%.”⁹

In Scotland, there are no targets for the proportion of the population who should be able to access psychological therapies. However, a total of 778,180 patients were dispensed at least one antidepressant during 2013/14¹⁰. By comparison, between 2014-15, 39,870 people started psychological therapies in Scotland¹¹. Even allowing for the fact that people are prescribed antidepressants for issues other than mental health problems, this indicates that many more people in Scotland could benefit from therapies.

6 ISD, [Psychological Therapies Waiting Times](#), February 2016

7 Department of Health, [Talking Therapies: A Four Year Plan of Action](#), 2011

8 Department of Health, [IAPT Three-Year Report: the first million patients](#), 2012

9 Department of Health, [IAPT Three-Year Report: the first million patients](#), 2012

10 ISD, [Medicines for Mental Health](#), 2004/05-2013/14

11 Aggregation of quarterly statistics from ISD, Psychological Therapies HEAT Access Target, 2014-15

OUR RESEARCH

Methodology - survey

Between April-May 2015, SAMH conducted an online survey seeking views on experiences of accessing psychological therapies. The focus was exclusively on people aged 18 years or over and living in Scotland.

There were 494 responses to the survey (once those who did not satisfy the eligibility criteria were either routed out or removed). Of these, 72% (N=356) had been referred and/or were receiving therapy; 6% (N=28) had asked to be referred but been told that they did not qualify; and 22% (N=110) indicated that someone who was very close to them had tried to get access to, or had received, a psychological therapy in the past four years. Our analysis focuses primarily on those who had personally been referred for psychological therapies over the past four years (N=356).

There is a notable gender bias in responses to our survey: 72% of those who had been referred were female. While women are more likely to have been treated for a mental health problem than men¹², we do not know whether this is the reason for this bias: as the survey was primarily distributed via social media and e-newsletters, it may simply reflect the make-up of SAMH's online audience.

We also asked about age and ethnicity. Just 1% of those who had been referred were from a BME background, while the dominant age group was people in their thirties.

Methodology - Freedom of Information requests

Between December 2014 and January 2015, SAMH submitted Freedom of Information requests to the 14 Scottish NHS Health Boards, requesting data on the different types of therapy they had provided between 2013-14 and the levels of access and usage of therapies by people from different equalities and social groups (full text of questions is provided in Appendix 1).

Age group	% of those who had been referred for a psychological therapy	N
18-20	4%	15
In your twenties	18%	63
In your thirties	26%	91
In your forties	20%	70
In your fifties	17%	59
In your sixties	3%	9
Over sixty	1%	4
Did not answer question	13%	45
Total	102% (due to rounding)	356

Table 1 – Respondents by age

OUR FINDINGS

Key findings – survey

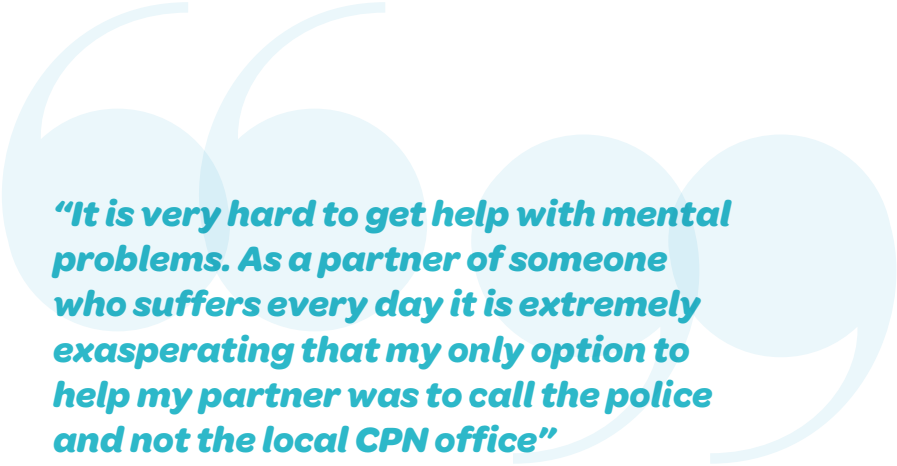
Reasons for receiving therapy

Depression or anxiety were by far the most common reasons for receiving therapy. This is not unexpected: between April 2012 and March 2013 in Scotland, over 219,840 patients consulted their GP or practice nurse at least once about anxiety and 160,490 consulted at least once about depression.¹³

Condition for which person was treated	% of those who had been referred	N
Depression	52%	185
Anxiety	45%	160
Did not answer question	31%	109
Other issue	11%	39
Post-traumatic stress disorder	10%	36
Personality disorder	8%	30
Bereavement	6%	27
Obsessive compulsive disorder	6%	21
Eating disorder	5%	19
Bipolar disorder	3%	12
Drug/alcohol problem	3%	9
Phobia	3%	9
Schizophrenia	<1%	3
Prefer not to say	<1%	1
Don't know	<1%	1

Table 2 – Reasons for receiving therapy

*NB a total of 236 people answered this question. However, many indicated that they had been treated for more than one condition. This also explains why the percentages column totals more than 100%.



“It is very hard to get help with mental problems. As a partner of someone who suffers every day it is extremely exasperating that my only option to help my partner was to call the police and not the local CPN office”

Waiting times

“It was a very difficult period in my life, and has become exacerbated through the waiting and unable to receive the correct help and the time I needed it most.”

Almost a fifth of people (N=61) who had been referred waited between 1-3 months for treatment to begin, while over a tenth (N=45) waited between 3-6 months.

Length of time waited	% of those who had been referred	N
A week or two	5%	20
2 weeks – 1 month	10%	36
1 – 3 months	17%	61
3-6 months	13%	45
6 months – 1 year	11%	38
More than a year	4%	14
I can't remember	5%	18
Did not answer question	35%	124
Total	100%	356

Table 3 – Length of time waited to receive therapy

Almost half of those (N=169) who had been referred for a psychological therapy had found the length of time they had to wait either very or quite difficult, while a quarter (N=88) said it was OK (the remainder did not express a view).

“The length of time between referral and actual admission for services, I believe there should be a “Stepping Stone” in between. Some form of counselling during the period of time it takes to be referred from GP to mental health services.”

The longer people waited for treatment, the more likely it was that their mental health deteriorated while waiting. In particular, after a waiting time of 3 months, there was an increased tendency for respondents to indicate that their mental health deteriorated.

30% (N=6) of those waiting just a week or two said their mental health got worse while they waited, compared to 62% (N=27) of those waiting 3-6 months, 73% (N=28) of those waiting 6 months – a year and 100% (N=13) of those waiting over a year.

“When you are very depressed you shouldn't have to wait for up to 3 months for someone to help you... I feel very let down by the NHS.”

Types of therapy

Cognitive Behavioural Therapy (CBT) was by far the most common therapy provided. It is notable that almost a fifth of those who had been referred for a psychological therapy did not know what type of therapy they had received.

Type of therapy	% of those who had been referred	N
CBT	40%	144
I don't know	18%	63
Other	17%	61
Psychoanalytic/psychodynamic psychotherapy	9%	33
Behaviour Therapy	4%	13
Interpersonal therapy	4%	13
Computerised CBT	2%	8
Humanistic therapy	2%	6
Systemic and Family Therapy	1%	4

Table 4 – Types of therapy provided

*NB a total of 287 people answered this question. However, some respondents indicated that they had received more than one type of therapy. It is not clear whether these additional therapies were received sequentially or concurrently

Of those who selected “other”, the most common responses were Dialectical Behaviour Therapy, Mindfulness, and Eye Movement Desensitisation and Reprocessing (EMDR).

“CBT has helped me greatly, I now know my triggers so much better and my recovery time from rock bottom was dramatically reduced from previous breakdowns having medicine alone”

By far the most common format of therapy was one- to-one, followed by group therapy.

Format of therapy	% of those who had been referred	N
One to one	59%	211
Group therapy	11%	40
Online	2%	7
Self-management	7%	26
Did not answer question	20%	72
Total	99% (due to rounding)	356

Table 5 – Format of therapy provided

Effects of psychological therapy

Respondents were clear that psychological therapies did help, both at the time and later in life. Three-quarters of those who had completed their therapy said it had helped at the time, and almost two-thirds said it still helped them now. More than half of those who had completed their therapy over two years ago said that the therapy still helped them now.

Benefit	Therapy has helped	Mixed views	Didn't help or made me worse	I don't know/ it's hard to say	Total
Finished...					
Less than a month ago	0	100% (N=2)	0	0	2
1-3 months ago	63% (N=10)	25% (N=4)	13% (N=2)	0	16
3-6 months ago	80% (N=12)	20% (N=3)	0	0	15
6 months to a year ago	69% (N=22)	19% (N=6)	13% (N=4)	0	32
1-2 years ago	59% (N=22)	19% (N=7)	19% (N=7)	3% (N=1)	37
More than 2 years ago	55% (N=23)	29% (N=12)	14% (N=6)	2% (N=1)	42
Total	89	34	19	2	144

Table 6 – Effects of psychological therapy now, by how long ago therapy was completed

"I personally have been very lucky in having an excellent and supportive consultant psychologist whom I have seen regularly for over seven years now. She, my GP and my psychiatrist all provide me with support."

Thirty-eight per cent (N=55) of those who expressed a view felt they had received too few sessions of therapy, compared to 61% (N=89) who felt it was about right. Those who felt they'd received the right amount of sessions were far more likely to think that therapy had helped them.

"I felt that the therapy ended because I only had a designated number of sessions rather than because I was finished. I had to seek private therapy to address the issues left unresolved"

"My husband has suffered with anxiety and depression for about 16 years. Sadly it wasn't until he had caused himself liver damage through self-medicating he received the support he needed. Thankfully now his mental health is much better but will always be an issue for him."

"I found CBT to be very helpful at the time, but within a year felt myself slipping back into depression and having panic attacks again. I feel it would be extremely helpful if, after the initial course of treatment, some follow-up or 'refresher' sessions were available on, say, a 6 monthly basis"

	Therapy has helped	Mixed views	Didn't help or made me worse	I don't know/ it's hard to say	Total
Too many sessions	50% (N=1)	0	50% (N=1)	0	2
About the right number	74% (N=66)	19% (N=17)	6% (N=5)	1% (N=1)	89
Too few sessions	42% (N=23)	36% (N=20)	22% (N=12)	0	55
Total	90	37	18	1	146

Table 7 – Effects of psychological therapy now, by views on number of sessions received

KEY FINDINGS – FREEDOM OF INFORMATION REQUESTS

Types, levels and combinations of therapies provided

Most health boards do not appear to be closely monitoring the types of psychological therapies they are providing.

We asked for information about the use of different types, levels of intensity and combinations of psychological therapy provided, between the 12 months from Oct 2013 to end of Sept 2014. This is in line with the NHS Education for Scotland guidance document The Matrix, which makes clear that psychological therapies should be delivered as part of a matched/stepped care model. This means that services are provided using a tiered approach, with high-volume, low intensity interventions being provided to people with the least complex difficulties. The Matrix refers to four different levels of treatment:

- Low Intensity
- High Intensity
- Specialist
- Highly Specialist

In particular, the Matrix states:

“There should be continuous monitoring and feedback on the performance of the matched/stepped-care model and referral system, and outcome data should be used to drive improvement”.

The responses to our FOIs would suggest this is not taking place consistently across Scotland.

Four geographic health boards provided some data about the types of therapies provided (NHS Shetland, NHS Grampian, NHS Greater Glasgow and Clyde, and NHS Borders). NHS 24 also provided information, but it provides only CBT and Guided Self-Help.

Cognitive Behavioural Therapy was the most commonly provided therapy in both NHS Borders and Greater Glasgow and Clyde: these were the only boards which provided this level of detail. NHS Borders could only provide it from August 2014 onwards.

Seven health boards cited Section 12 of the Freedom of Information Act (FOIA) in response to this question, stating that it would be too expensive to collect this data from individual patient records. Three cited Section 17 (no data of any type being collected) and three stated that there was no data monitoring system in place.

NHS Highland was able to provide data about the relative provision of low intensity and high intensity therapies (although not specialist or highly specialist). NHS Borders provided some information in response to this question. Nine were unable to provide any data: three cited Section 12 of the FOIA, four Section 17 and two said they had no system in place.

No health board was collecting information about the combination of therapies that people were offered, which seems surprising given the emphasis on the stepped or matched model in the Matrix.

Equality of access to psychological therapies

Most health boards do not appear to be monitoring equalities data about which groups are accessing psychological therapies

Eight geographic health boards, plus NHS 24, could provide full or partial monitoring data in relation to age and gender, but little other data of substance from the other protected characteristics under the Equality Act was provided¹⁴. Only NHS Shetland and NHS Lothian recorded aggregate data on ethnicity. Half of health boards could provide no equalities data whatsoever.

An initial analysis of the age and gender data that was provided indicates:

- a falling away in numbers for older people accessing psychological therapies in comparison to those of working age and children/young people.
- generally more women than men receiving therapies.

Only NHS Highland was able to produce data in relation to access to psychological therapies by people from different socio-economic groups, with reference to the Scottish Index of Multiple Deprivation (SIMD). This illustrated below average access in the 30% most deprived communities and 20% least deprived communities.

Health boards are subject to the Public Sector Equality Duty introduced by the Equalities Act (2010), which requires them to eliminate discrimination and advance equality of opportunity. It is difficult to see how they can do this in relation to equal access to psychological therapies if they are not monitoring the data.

14 The other protected characteristics are disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief and sexual orientation

CONCLUSION

Scotland should be proud of its record as the first country in the world to introduce waiting times for psychological therapies. However, our research, alongside official statistics, demonstrates that people are still waiting too long, and that this has a serious impact on their mental health. It is clear from our findings that psychological therapies are helpful and could potentially benefit many more people in Scotland.

We welcome the work that has begun in Scotland, but this is only the beginning. We hope that our recommendations will be implemented to ensure that as many people as possible can be helped on their journey to recovery from mental health problems through accessing psychological therapies.

APPENDIX 1 – INFORMATION REQUESTED FROM HEALTH BOARDS

(1) Re. Data on the use of different types of psychological therapy between the 12 months from Oct 2013 to end of Sept 2014 – we request:

- Aggregate data, and related reporting, from across the Health Board's psychological therapies service(s) on the types of the different psychological therapies that have been provided.
- Aggregate data, and related reporting, from across the Health Board's psychological therapies service(s) on the levels of usage of 'low intensity', 'high intensity', 'high intensity specialist' and 'highly specialist' psychological therapies/interventions that have been provided (*see note *1*).
- Aggregate data, and related reporting, from across the Health Board's psychological therapies service(s) on the different *combinations* of types of psychological therapies that have been used by those people/patients receiving treatment – as per the matched/stepped model of provision of psychological therapies (*see note *1*).

(2) Re. Data on the access and usage by different social groups and classes of psychological therapy service(s) between the 12 months from Oct 2013 to end of Sept 2014 – we request:

- Aggregate data, and related reporting, from across the Health Board's psychological therapies service(s) on the levels of access and usage by different protected groups/characteristics as defined by the Public Sector Equality Duty in Scotland, including: gender; ethnicity/race; disability; age; religion; sexual orientation; gender reassignment (transgender); and pregnancy/maternity (*see note *2*).
- Aggregate data, and related reporting, from across the Health Board's psychological therapies service(s) on the levels of access and usage according to socio-economic circumstance including: (i) by 'employment status/income circumstance' or similar (*see note *3*); and (ii) by residency in data-zones as rated by the Scottish Index of Multiple Deprivation (SIMD) (*see note *4*).

Notes:

*1: definition(s) from NHS Education for Scotland's (2011) *Matrix: a guide to delivering evidence-based psychological therapies in Scotland*: <http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/matrix.aspx>

*2: as per Public Sector Equality Duty Scotland guidance: <http://www.equalityhumanrights.com/about-us/devolved-authorities/commission-scotland/scotland-guidance>

*3: for instance, to include whether someone is understood to be: employed, unemployed, a full-time carer, retired, in education and/or training, receiving Employment and Support allowance, or a child/young person under 16 years of age.

*4: where data-zones indexed as '1' by the SIMD index are in the 10% most deprived in Scotland, and those indexed as '10' are in the 10% least deprived in Scotland; see SIMD 2012 web portal: <http://simd.scotland.gov.uk/publication-2012/>

NB: slightly different text was submitted to NHS 24 to reflect the fact that it is not a geographic health board