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Invited commentary . . . On poverty, politics and psychology†

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Summary
Associations between deprivation and mental health have long been known. This commentary discusses recent work examining this in relation to the uptake, delivery and outcomes of psychological therapies in England. These associations are complex but it is clear that implementation of evidence-based interventions should consider area-level characteristics.

Declaration of interest
None.

In their analysis of services delivered under the Increasing Access to Psychological Therapies (IAPT) programme in England, Delgadillo *et al* have demonstrated that area-level deprivation is positively associated with referrals into treatment but negatively associated with recovery rates.[1] Case-load size was not significantly associated with deprivation.

The study raises a number of intriguing issues. Greater throughput with the same case-load sizes in deprived areas is consistent with higher drop-out rates. Although findings are mixed on the stage in the pathway at which people in areas of high social deprivation are most likely to disengage, there is a consistent finding that they find it harder to continue in therapy to a planned ending.[2–4] Data on attrition are collected as part of the IAPT programme and this is worthy of further study.

Increased referral rates into the IAPT programme for areas with high levels of deprivation are consistent with the impact of deprivation on incidence of depression and other common mental disorders. This has been recognised at both the individual and area levels since at least the 1930s,[5] and continues to be observed.[6] Identifying causation is problematic and it is likely that deprivation can both lead to mental health problems and be intensified by them. To expect a perfect relationship between deprivation and mental health problems and subsequent treatment is unrealistic because of the plethora of other factors that are important. However, many of these will not be dependent on geographical area and so when comparing areas we should still be able to detect the impact that changes in economic factors might have. The UK economy like any other goes through periods of different rates of growth, and areas are affected differently. Investigation of these period changes on mental health referrals is viable and should be encouraged.

However, the incidence of common mental health problems is not the only determinant of referral to the IAPT programme.[7] What is not investigated in the analyses (and it is unlikely that this would be possible) is the extent of the treatment gap that may still exist and whether this differs by area. A key question is whether individuals referred to IAPT are representative of those with common mental health problems in the local population. For example, those referred may have more severe problems, be younger and more likely to be women.[8]

Lower rates of completion of therapy may also contribute towards poorer outcomes in areas of high deprivation, although it is likely that outcome measures are not completed by those who drop-out. Identifying other reasons for the poorer outcomes in more deprived areas is important. It could imply that severity of problems is greater in these areas, that there are differences in the quality of care or that the formats of therapy offered are less culturally appropriate in these areas. Another consideration is economic. In the UK, the IAPT programme is one element of mental healthcare and as a proportion of total spend it differs markedly by area. While total spend on the National Health Service has to some extent been ring-fenced, and the importance of mental healthcare within this has been recognised, the system is still under strain. The £20 billion efficiency savings required will affect mental health as with other areas. Local authority spending on social care has been reduced in recent years and this has likely had an impact on the ability of mental healthcare services to function efficiently and to provide an optimum level of service. Cuts to other local authority services and grants to third-sector providers is also going to have a detrimental effect. Such impacts not only reduce the amount of service provision but they may themselves have an impact on the occurrence of mental health problems in the first place.

Although Delgadillo *et al* put forward an argument that 'recovery targets' should be adjusted for social deprivation, at the same time they rightly inveigh against using the term 'recovery' to refer to what may be a short-term improvement in reported mental health at the end of therapy. It is worth noting that mental health service users consulted on this issue felt that services should examine the long-term effectiveness of therapy through follow-up questionnaires.[9]

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