

Effekten af den gratis psykologhjælp; a summary of the clinical and economic benefits from the first ten years of the IAPT programme in England (2007 – 2017).

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In 2007, the British government launched a mental health initiative called ‘Improving Access for Psychological Therapy’ (IAPT), which hugely expanded the provision of talking therapies within the English National Health Service. Developed by Professor David Clark in collaboration with Lord Richard Layard, it is the biggest expansion of mental health services anywhere in the world, and arguably the only instance of a government providing free talking therapy on a mass scale.

The IAPT programme is a means of delivering National Institute for Clinical Excellence (NICE) recommended (evidence-based) talking therapies to a clinical population with mild to moderate anxiety and depression within a ‘stepped-care’ model (low-to-high). A key component of the IAPT programme relates to (easy) access, via a General Practitioner (GP) or self-referral.

The aims of the IAPT programme included: better health and wellbeing of the population, increased choice and accessibility to clinically effective evidence-based services, high satisfaction with services received, and to help people stay employed and able to participate in activities of daily living.

Set-out below is information regarding the **clinical** and **economic benefits** of the IAPT programme drawn from research literature, as well as national and local reports, and other grey literature including presentations, interviews and personal communication with Professor David Clark. Included in this summary is information regarding a number of ‘**other considerations**’ which may impact on the clinical and economic benefits.

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Background

How it started

A chance encounter at the British Academy led to a conversation between Lord Layard and Prof Clark and the subsequent development of the IAPT model. In a paper entitled ‘Mental Health: Britain’s Biggest Social Problem?’ (Layard, 2004) presented at a government strategy meeting in 2005, Lord Layard proposed that if unemployment had been the biggest source of misery in the 1990s, that role had been taken on in the subsequent decade by mental ill health.

He argued that successes in tackling unemployment needed to be followed up by aggressive measures to tackle common, disabling mental health problems. He drew attention to the English national Psychiatric Morbidity Survey (2000), which suggested that at any one time 16% of adults suffer mental ill health, with knock-on effects for their families and carers. He asserted that effective treatments, although developed, were not readily available because services did not exist to deliver them on the scale needed. Furthermore, that, even when evidence-based psychological therapies were available, there were long waiting lists (6 months or more) before they could be accessed.

“Mental illness matters because it causes massive suffering to patients and their families, because it prevents them contributing fully to society, and because it imposes heavy costs on taxpayers.”
(Layard, 2004)

Crucially, Lord Layard suggested that the cost of mental ill health went beyond the subjective and hard to quantify personal cost borne by sufferers. There were quantifiable (and very large) costs to the public purse as well as more widely to society as a whole – for example in lost production due to inability to work.

The argument developed by Clark & Layard

In rich countries, 38% of all illness is mental illness (p. 43–45, Layard and Clark, 2014b - see Figure 1). It particularly affects people of working age where it accounts for 50% of the total (see Figure 2). The overall economic cost has been estimated at 8% of GDP, not to mention the massive suffering involved.

Figure 1. Forms of ill health affecting adults

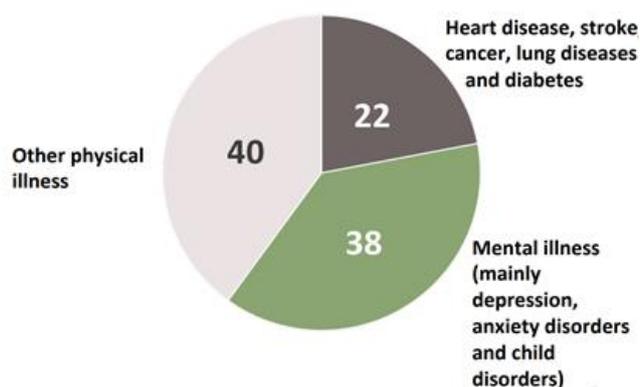
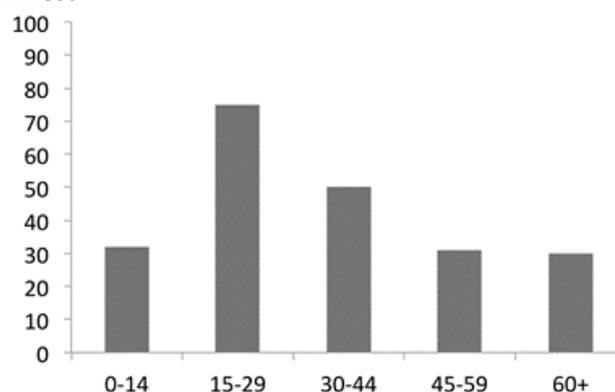


Figure 2. Percentage of morbidity due to mental illness



The economic cost is significant

Depression is 50% more disabling than angina, asthma, arthritis or diabetes and mental health problems account for 40% of disability benefits and 40% of absenteeism. Overall, the cost to economy is c. £70 billion and the cost to taxpayers is c. £35 billion per year (Layard and Clark, 2014).

Savings to the economy

The long-term (5 year) costs due to implementation of the IAPT programme would be 'off-set' by the savings made on physical healthcare, benefits and lost taxes:

- Gross cost per person treated = £650
- Savings on physical healthcare > £650
- Savings on benefits & taxes > £650

Progress in psychological treatment

NICE recognizes the advance in psychological treatment research and as such, recommends evidence based psychological therapies as first line treatments for depression, anxiety related disorders, eating disorders and personality disorders. However, most of the people who require these interventions don't benefit from them because so few (less than 10%) adults with anxiety or depression receive evidence-based psychological therapy.

The IAPT programme therefore aimed to vastly increase the availability of effective (NICE recommended) psychological treatments for depression and all anxiety disorders by:

- training large numbers of psychological therapists
- deploying them in specialized, local services for depression and anxiety disorders
- measuring and reporting clinical outcomes for all patients who receive a course of treatment (public transparency)

The National Plan (2008-2020)

The national plan involved training at least 9,000 new therapists and employing them in new clinical services for depression & anxiety disorders. Using NICE Guidelines (including stepped care) to develop a national curriculum to train high and low intensity practitioners (Psychological Wellbeing Practitioners: PWP) with a clearly defined set of competencies for all therapies (Roth & Pilling, 2008).

Success of the IAPT programme would be judged against clinical outcomes (50% recovery target), referral figures (including self-referral) and session by session outcomes measurement using standardized tools.

In terms of access targets, the aim was to have contact with 15% of prevalence 2015, and 25% by 2020.

Development of the demonstration sites

By February 2006 two demonstration sites (Newham and Doncaster) were identified and the initial form of the services sketched out. The plan was for the two demonstration sites to bring together a model of multi-disciplinary delivery of psychological therapies for people with mild to moderate depression. The model was expected to include the following characteristics:

- A team approach to delivering therapies in a stepped care context (low-to-high)

- A hub and spoke model with outreach into primary care practices. The area to be covered by the team would be a Borough (small geographical area)
- Therapy according to NICE guidelines (NCCMH, 2004; NCCMH, 2009) with appropriate follow up and medication if needed in addition to CBT, which is the main therapeutic intervention. The NICE 2002 and 2004 depression guidelines recommend
 - o Step 1 watchful waiting
 - o Step 2 self-help including bibliotherapy, computerised CBT, and/or practice-based counselling
 - o Step 3 CBT and/or medication
- Strong leadership by a psychologist
- Best practice in terms of training, supervision and peer support for therapists of all professions who provide talking therapy, in particular those who provide primary care, e.g. counsellors, practice staff and general practitioners
- Access to employment and housing advice at team level
- Collection of data routinely on process and outcomes (the latter using validated outcome measures).

Clinical Factors

Measures

Detailed outcome monitoring and ongoing evaluations of the programme are considered an integral part of IAPT. The programme stipulates a minimum dataset, which records the care provided to each patient and his or her clinical progress. High levels of pre-post data completeness are achieved by the use of a session-by-session outcome monitoring system that guarantees that a clinical endpoint is available even if a patient ends therapy earlier than expected (Gyani et al., 2013).

IAPT service protocol states, each client at each contact should complete two routine outcome measures:

PHQ-9

The Patient Health Questionnaire (PHQ-9) used to measure the severity of depressive symptoms. This is a nine-item standardised measure which has been validated in a UK depressed population (Cameron, Crawford, Lawton & Reid, 2008). The scores range from 0 to 27, with a score of ten or more being the threshold to identify clinically relevant depressive symptoms (Kroneke, Spitzer & Williams, 2001).

GAD-7

The General Anxiety Disorder Questionnaire (GAD-7) has also been determined to have good psychometric properties having been validated in U.S. populations. The scores range from 0 to 21 and a score of eight or more being the threshold to identify clinically relevant general anxiety disorder (Kroneke et al., 2007).

Improvement is determined using a reliable change index whereby six and four indicate reliable change in depression (PHQ-9) and anxiety (GAD-7) respectively. Recovery requires a demonstration of reliable improvement, with final scores below clinical thresholds, on both psychometric measures at the end of treatment.

Adherence to clinical guidelines

In 2004, NICE carried out systematic reviews of research investigating the effectiveness of interventions for depression and anxiety disorders. The resultant clinical guidelines advocate the provision of specific kinds of cognitive behavioural therapy (CBT) for depression and anxiety disorders (NICE, 2004). Crucially, cognitive behavioural therapy is considered to be more effective than medication given that it reduces the likelihood of relapse by at least 50%, and moreover, the vast majority of patients prefer it to a psychological treatment (McHugh et al., 2013). NICE guidelines recommend that mild to moderate depression and anxiety can be managed effectively using low intensity interventions within primary care level settings (DSSPS, 2005). Furthermore, low intensity interventions improve the flexibility, capacity and responsiveness of the relevant services while increasing patient-choice, and enhancing service cost-effectiveness (Bennett-Levy et al., 2012).

Clinical components of IAPT

IAPT services offer 'stepped care', which means providing the appropriate level of help delivered by the right person at the right time. For many people, a 'low intensity' intervention is best – for example guided

self-help, computerised cognitive behaviour therapy (CCBT) using programmes such as 'Beating the Blues' (<http://www.beatingtheblues.co.uk/>) and 'Living Life to the Full' (<http://www.lltf.com/>). When symptoms are more severe or problems complex, a longer course of 'high intensity' therapy will be required as indicated in NICE Guidelines.

IAPT services see many clients who were previously treated in primary care (via GP's), some who were treated in secondary care, and many who would not have been treated at all. IAPT is therefore blurring the boundaries between primary care and secondary mental healthcare – a form of intermediate care. To be effective, IAPT services cannot be isolated but must work in partnerships with both primary and secondary care practitioners as well as with those services provided by voluntary and independent organisations (Holland, 2009). If clients are to receive the right help at the right time, then good communication and local agreements are essential between all these agencies.

Clinical outcomes to date

Over the lifetime of the IAPT programme, there have been several reviews of the IAPT programme which include clinical outcomes; for example:

1. **Clark, Layard & Smithies (2008):** which provides an initial (first 13 months) evaluation of the two demonstrations sites, including:
 - **Numbers treated.** Nearly 5,500 people have been referred, of whom 3,500 have concluded their involvement with the services. Around 1,900 of the concluded cases received at least 2 sessions of treatment.
 - **Completeness of outcome monitoring.** Session by session use of the PHQ and GAD has ensured that the sites have almost complete data on pre to post-treatment changes in depression and anxiety (99% of treated cases in Doncaster and 88% in Newham, despite the significant number of people who do not speak English). Data completeness is less impressive (56% or less) for measures that were only intended to be collected at pre- treatment and posttreatment.
 - **Psychological Benefits.** Both demonstration sites achieved good recovery rates (52%) for people who had depression and/or an anxiety disorder for more than 6 months. Furthermore, the follow-up data suggests that these gains are largely maintained 4-12 months later.
 - **Self-referral.** Approximately one-in-five people seen in Newham referred themselves to the service. Providing a self-referral route appears to have enabled the service to access disabled individuals in the community who are not well served by existing referral routes. Compared to GP referrals, self-referrers are at least as unwell, tend to have had their problems for longer, and more closely match the ethnic mix of the community.
2. **Department of Health (2012) 'IAPT three-year report; The first million patients':** which includes the following findings:
 - **Treatment:** More than 1 million people in IAPT services and more than 680,000 people completing a course of treatment
 - **Recovery rates:** Recovery rates consistently in excess of 45% and approaching those expected from the randomised controlled trials that generated the initial NICE recommendations. Cumulatively

nearly 250,000 ‘cases’ (41%) recovering, and around two-thirds of those treated showing reliable improvement, i.e. achieving significant improvements in symptoms but not achieving the technical definition of recovery

- **Data collection:** A session-by-session outcome monitoring system, collecting data on 90% of contacts with service users
- **Workforce:** Training of a new, competent workforce of nearly 4,000 new practitioners, to deliver NICE-recommended treatments

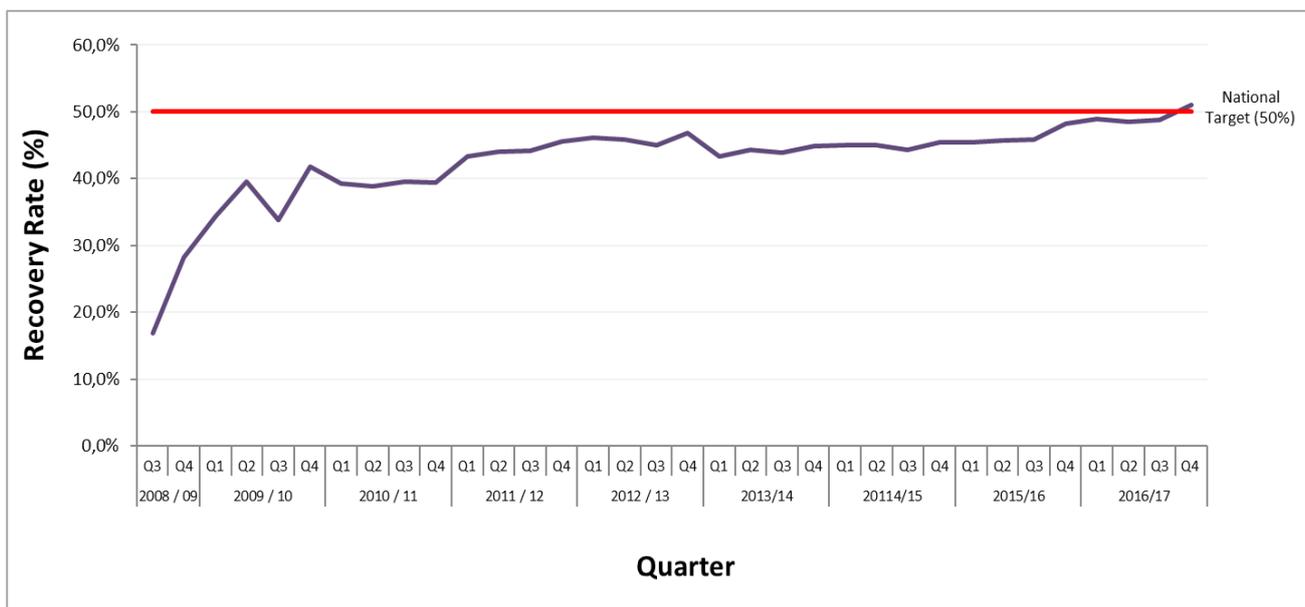
3. Clark and Layard (2014) Thrive: which is the most thorough review of the evidence of the IAPT programme to date.

Nationally

In their review of the IAPT evidence, Clark and Layard (2014) argue that the implementation of IAPT has transformed treatment of anxiety and depression in England. Stepped-care psychological therapy services have now been established in every area (CCG) of England. Against a target of 15% local prevalence to be treated by IAPT, 2017 data indicate approximately 17% of local prevalence (950,000 per year) are seen in services, and around 60% have course of treatment (approx. 575,000 per year).

Outcomes data are recorded in 98% of cases (pre-IAPT 38%) using strict (depression & anxiety) recovery criteria. As of 2017 (Quarter 4), national data indicated that 51% ‘recover’ and further 16% ‘improve’ (thus going beyond the 50% target set-out in 2007).

Figure 3. IAPT national recovery rates (Q3 2008/9 to Q4 2016/17)



Area (CCG) level data

Currently, 55% of areas (as defined by Clinical Commission Group – CCG) have recovery over 50%, some are over 60%.

- Recovery rate: 51% (range 35% to 71%)
- Reliable Improvement: 66% (range 35% to 80%)
- Reliable deterioration: 6% (range 3% to 10%)
- Average number of sessions: 6.3 (range 2.3 to 9.4)
- Percent of sessions patients 'do not attend (DNA)': 12% (range 5% to 27%)
- Average wait time: 30 days (range 5 to 154 days)

Table 2. Recovery range by CCG

Recovery Range	Number of CCGs
Over 50%	148
45% - 50%	31
40% - 45%	15
Below 40%	9

NB: Detailed service-level data are available via a public database: <http://content.digital.nhs.uk/iaptreports>

Services level data

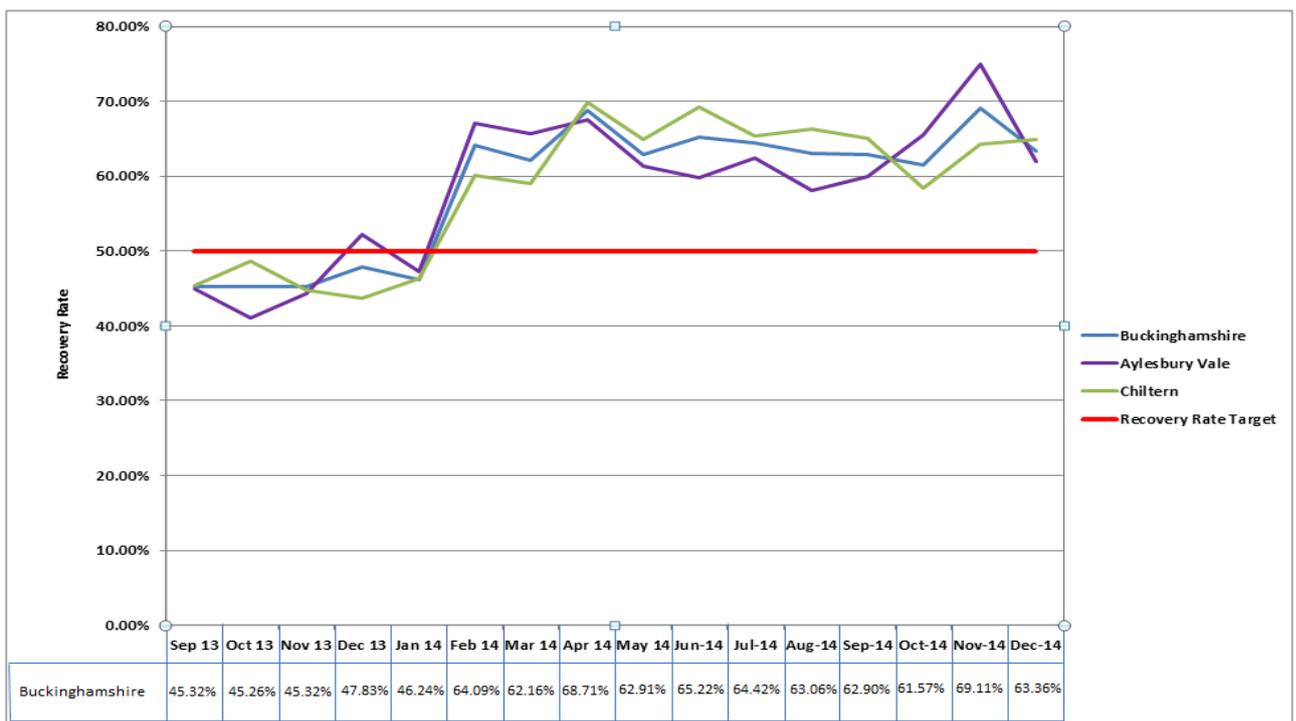
Services which consistently record higher recovery rates share a number of characteristics, firstly that patients attend on average, a higher number of sessions, indicating a 'dose-effect'. These services also maintain high fidelity to the 'stepped-care' model, employ a core group of experienced staff who deliver NICE compliant treatment, and accept higher proportions of 'self-referred' patients. The data also indicate that initial clinical severity also predicts recovery. Below are themes identified at an IAPT workshop attended by 'high performing' IAPT services (NHS England, 2015):

- **Excellent leadership, with a real focus on recovery:** the overarching requirement for good leadership is not only at senior level but at team level, and includes: feedback of individual therapist performance, individually tailored Continuing Professional Development (CPD) for staff; benchmarking and active decision making by the whole team; individual accountability; and a culture of enquiry.
- **Optimised performance management systems:** including clinical supervision with a focus on data and recovery performance; accessible, reliable and complete data; tracking outcomes at an individual therapist level and including this as part of performance management activity; good clinical productivity.
- **Workforce stability and experience:** the best performing providers have good retention rates and experienced workforces.
- **Assessment and access:** providers put an emphasis on correct assessment and getting the patients to the right therapists within waiting time targets – this includes an accurate judgement of their presenting problems (including provisional diagnosis using ICD10 codes).

- **Choice of NICE compliant treatments and access to alternative pathways:** discussing treatment choices with patients and identifying step-up or step-down options when appropriate.
- **Flexible number of sessions fitting clients' needs:** well performing providers generally had an open-ended approach to the overall number of sessions that could be offered. However, therapists and clients discussed sessions in terms of relatively short 'blocks' to help focus the therapist and client on making progress (e.g. six sessions followed by a review and further such blocks as appropriate).
- **Commissioning:** commissioning has a significant role to play in high performing services, ensuring investment and sensible contracting, monitoring and discussion of outcomes, and avoiding perverse incentives.
- **Data informed, service level reflective practice:** dramatic and sustained increases in recovery rates (45% to 65%) have been achieved by systematically reviewing all non-recovered cases and taking specific actions on the themes identified as reasons for non-recovery.

A small number of IAPT services have use a quality improvement approach (Plan-Do-Study-Act methodology) to increase recovery rates in their service. Consequently, they saw an increase from 45% to 65% over a 12-month period.

Figure 4. Increase in recovery rates over time using Quality Improvement (PDSA) approach



Patient level

Professor Clark acknowledges that variability in clinical outcomes between services is a concern and must be one of the next areas of focus. A review of the data indicates that recovery rates are higher when therapists follow NICE recommended treatments closely, for example, self-help treatment for depression leads to recovery in 50% of cases if it is 'guided' (NICE recommended) compared to 36% when not.

Similarly, generalized anxiety disorder treatment is significantly more effective if CBT (55%) or Guided self-help (59%) is used compared to counselling (46%).

Other predictors of service-level variation in improvement and recovery rates include: the completeness of the 'problem descriptor' at initial assessment, the average waiting time (see figure 5), the average number of sessions received (see figure 6), DNA rate and local levels of social deprivation.

Figure 5. Average waiting time

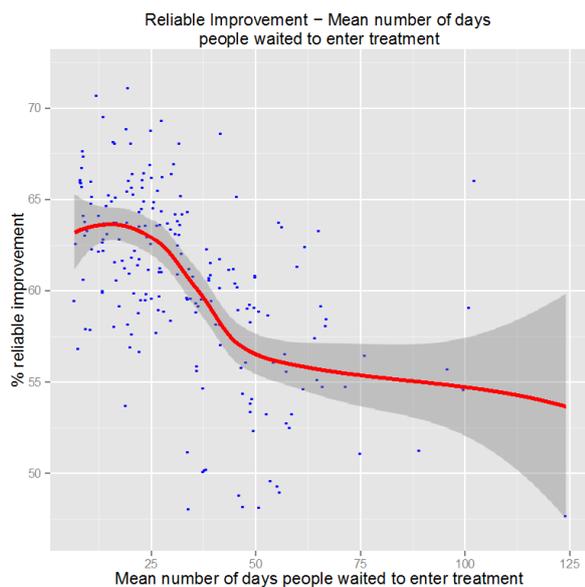
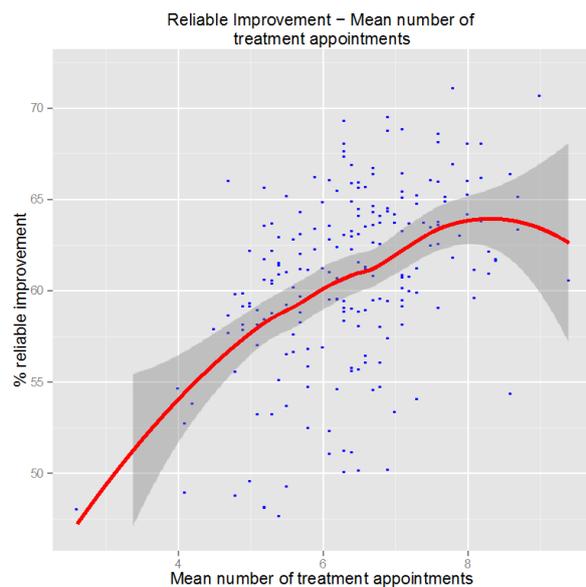


Figure 6. Average number of sessions



Criticisms of findings to date

Definition of recovery

In a paper by Griffiths and Steen (2013), they present a case for viewing the outcome data with caution. They state that the key clinical outcome indicators for the IAPT programme as published by the Department of Health (DH) currently focus on patients 'completing treatment' as a denominator for calculating rates of 'moving to recovery'. However, using those 'starting therapy' as a denominator, the rate falls (from 44% in 2013) to 22%. Using 'all patients referred' to the IAPT programme as the denominator, the figure is lower still, at 12%.

As such, recognition and understanding of the needs and experience of the high proportion of patients who have one or fewer contacts with therapists should be a high priority in the development of commissioning for psychological therapy. From this perspective, the denominator of patients referred, rather than patients completing treatment, may produce a more meaningful picture of outcomes for people commissioning services (Griffiths & Steen, 2013a).

Economic Factors

Background

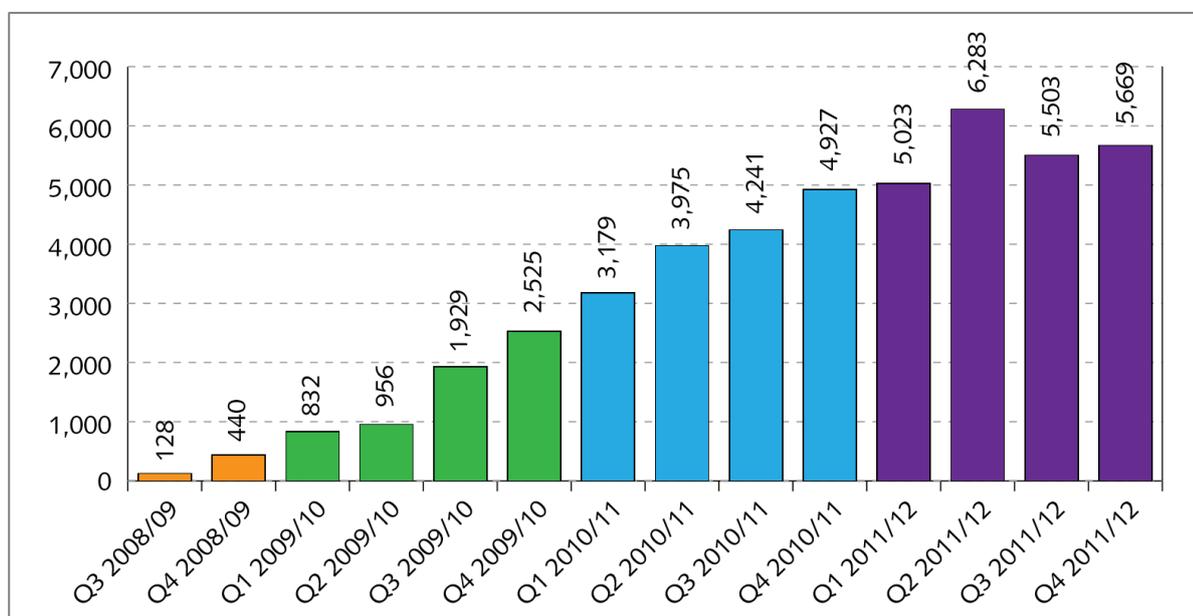
Clark and Layard (2007) argued that investment in mental health care is also important for socioeconomic reasons because mental illness is the main illness of working age. In most rich countries about 1% of the working age population is on disability benefits due to depression or anxiety disorders. Clark and Layard (2015) argue that in Britain, one such person costs the government £650 a month more than if they were not on benefit. (This includes both the benefits and reduced tax payments.) If, as a result of the IAPT treatment, 4% of those treated worked an extra 25 months, the average patient would be working one month more than otherwise. This would be enough to repay the cost of the treatment.

Findings to date

Compared to the clinical data, there are less data available against which the economic benefits of the IAPT programme can be assessed. In their initial evaluation of the two demonstration sites Clark, Layard & Smithies (2008) state that at the end of treatment 5% more of the treated population was in employment (range 4% to 10%), and that this was supportive of the assumptions made initial proposal. However, across the two sites, data were available for only 254 patients.

However, the Department of Health (2012) 'Three-year report' states the programme has made good progress in helping people move off sick pay and benefits, and that this has continued to increase in each year of the programme, with more than 45,000 people to date no longer receiving sick pay and/or benefits.

Figure 7. Number of people moving off sick pay and benefits, Q3 2008/9 to Q4 2011/12



Economic benefits relating to IAPT and Long-term (physical health) conditions

Around one third of people with long-term physical health conditions such as diabetes, cardiovascular disease or respiratory disease, have a coexisting mental health problem. Where a mental health problem

coexists with a long-term physical health problem, the potential for harm is greater. This includes poorer health outcomes, reduced quality of life and considerably higher healthcare costs.

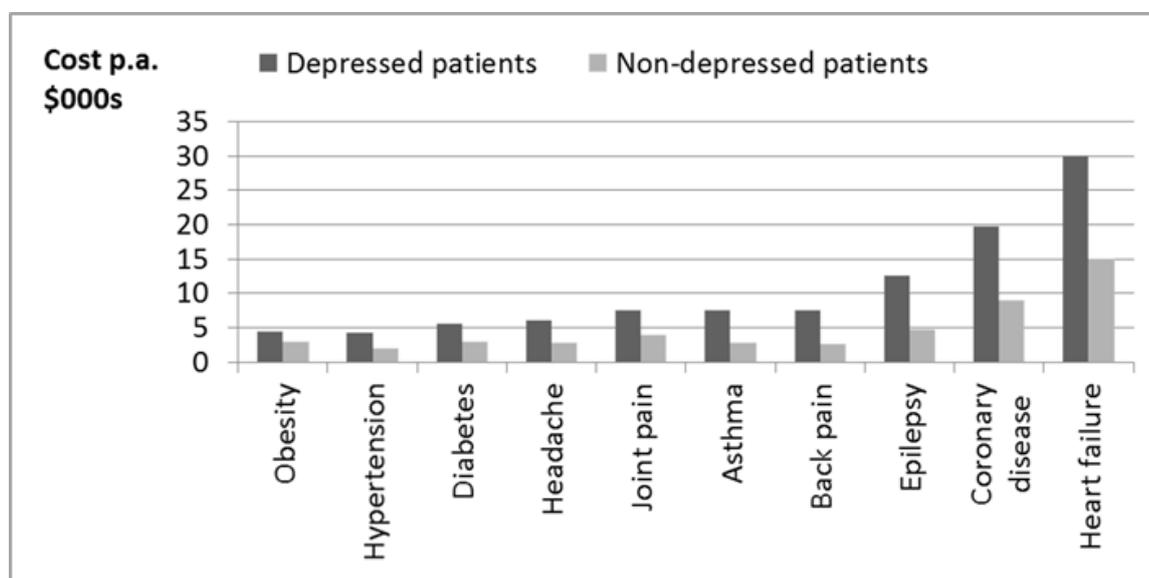
There is good evidence that psychological interventions can save 20% of physical healthcare costs (Chiles et al., 1999). In Britain, the cost of physical healthcare is around £2,000 extra when the patient is also mentally ill. Therefore, a physically ill person treated with IAPT for their mental illness could result in a saving off up to £1,000 a year on physical healthcare (due to the 50% recovery rate in IAPT).

The evidence for physical healthcare savings is strongest in the following areas (Layard & Clark, 2014):

- Diabetes - an IAPT pathfinder site found a net cost reduction of £372 for people with co-morbid diabetes and common mental health problems.
- Cardiovascular disease - an intervention in people with angina reduced both admissions by 33% and length of stay in patients the following year, with savings of £1,337 per person in 2007.
- Respiratory disease, particularly COPD - in Hillingdon Breathlessness Clinic gross savings of £837 per person over 6 months in secondary care costs (fewer A&E presentations and bed days when admitted), and £1,300 in overall healthcare costs over 6 months.

Figure 8 shows some figures on the effects of depression from the Colorado Access insurance scheme (Welch et al., 2009).

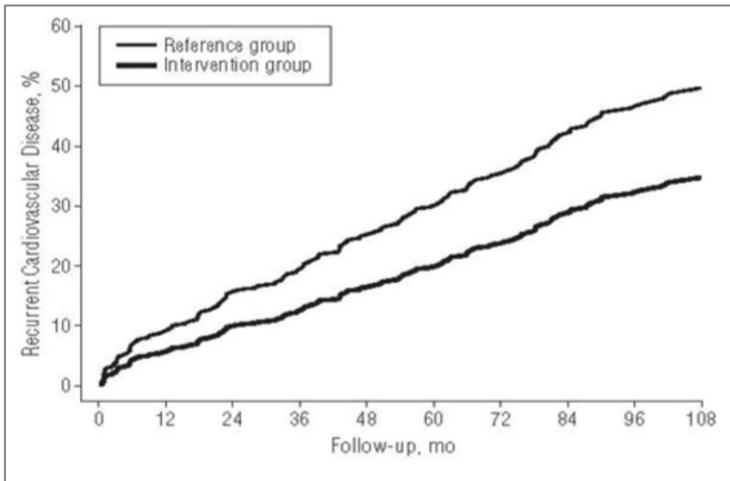
Figure 8. Depression increases the cost of physical healthcare.



Potential savings may be even greater if the psychological therapy is explicitly tailored to consider the physical problem, such as breathlessness, heart, or back pain. Innovations of this kind have shown savings in the cost of physical healthcare, often up to four times the cost of the psychological therapy.

For example, Figure 9 shows the progress of Swedish patients discharged from hospital following a heart attack. One set of patients was given group cognitive-behavioural therapy in twenty sessions over a year, the other was given none.

Figure 9. CBT reduces the recurrence of cardiovascular disease



One general medical practice in England has tracked the physical healthcare costs of its mentally ill patients and found cost saving benefits. They tracked all their mentally ill patients and compared those who had been treated by the programme with those who had not. The difference in physical healthcare costs was about £750 a year. This compares with the one-off cost of £650 for the psychological therapy.

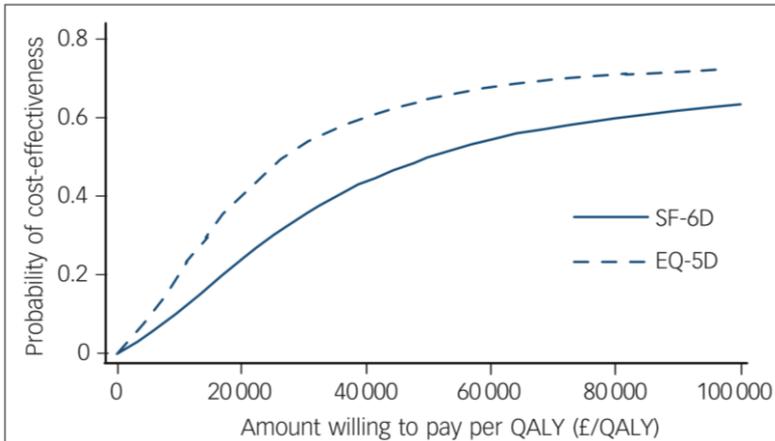
Challenges to the economic findings

The economic argument linked to the IAPT programme is not without its critics. For example, Thornicroft (2018) highlights that the original prospectus for IAPT relied heavily on delivering a strong return on investment from reductions in “presenteeism and absenteeism” (Layard & Clark, 2015), namely greater workplace productivity as a result of the treatment of employed people with anxiety or depression. However, little evidence has emerged that such productivity gains have been realized (Radhakrishnan et al., 2013; McCrone, 2013).

In one economic evaluation (Mukuria et al., 2013) which appears to support the cost-effectiveness of IAPT services, it has been highlighted that the cost per quality-adjusted life year (QALY) data is somewhat misleading (McCrone, 2013). He argues that the most useful results from the study relate to the cost-effectiveness acceptability curves (shown in Figure 10 below) which reveal that at the NICE upper threshold of £30000 per QALY, there is about a 38% likelihood that IAPT is cost-effective, increasing to just over 50% if the EQ-5D is used to generate QALYs. If the lower threshold is used, then there is even less chance that IAPT is cost-effective.

McCrone therefore suggests, “the overall conclusion of the economic evaluation should be based on Fig. 10 and it should be that on the basis of this study IAPT was probably not cost-effective.”

Figure 10. Short Form (SF-6D) and EQ-5D cost-effectiveness acceptability curves: IAPT v comparator sites



In a study attempting to estimate the cost associated with a single IAPT session, completed course of IAPT treatment and recovery, Muralikrishnan and colleagues (2012) found costs per session to be significantly higher than those originally proposal by Layard et al (2007). Specifically, it was estimated that the cost of providing a standard course of roughly ten sessions of CBT is £750 or £75 per session. However, these cost calculations were based on an average session cost of treatment in community mental health teams and treatment in a specialist post traumatic stress disorder clinic, neither of which use the ‘stepped-care’ and two-tier workforce model. Results from Muralikrishnan et al (2012), estimate the costs of a low- and high-intensity sessions at approximately £99 and £177, respectively. A similar analysis undertaken by Griffith & Steen (2013) suggests even higher cost per IAPT session of £102.38 for low intensity therapy, and £173.88 for high intensity therapy.

Other considerations

Fidelity to the IAPT model:

Findings indicate that the “pure” model of IAPT is increasingly being diluted as commissioners make pragmatic adjustments to the model (Griffiths & Steen, 2013). For example, to address the high dropout rate services are increasingly using group therapy as a means of significantly increasing the number of patients reached. A format not envisaged in the original IAPT configuration.

Patient ‘contacts’ (dose-effect)

Evidence of lower duration of therapy than that assumed by an earlier cost-benefit analysis of IAPT (Layard, Clark, Knapp, & Mayraz, 2007) adds another level of uncertainty to claims of health and economic benefit. Griffith & Steen (2013a) posited a mean number of sessions of 3.94 excluding one assessment session, compared to “roughly ten meetings” assumed by Layard and colleagues in the original design. The National Audit of Psychological Therapies found that “seventy per cent of patients who had high intensity therapy did not receive the minimum number of treatment sessions that NICE recommends and about half of these patients had not recovered by the time that therapy was discontinued” (Royal College of Psychiatrists, 2011).

This criticism has been acknowledged by Clark (person contact), who postulates a ‘dosing-effect’ of IAPT. As such, clinical outcomes may be increased relative to the number of sessions attended. It would therefore be critical to consider (systemic) factors which contribute to both low uptake (referral to attendance) and low ‘sessions-attended’ rates.

Patient Experience

Although patient experience data also indicates high levels of satisfaction with the IAPT services, these data constitute only a small proportion of patients who had been assessed (10%) or who had finished a course of treatment (11%).

Table 2. Patient feedback data

Post Assessment Questions	YES (%)	Post-treatment questions	% most or all times
Given information about options for choosing a treatment?	92.3	Staff listened to you and treated concerns seriously?	96.7
Did you have a treatment preference?	77.6	Service helped you better understand and address your difficulties?	91.5
Were you offered your preference?	77.8 (yes) 4.2 (no) 14.4 (n/a)	Felt involved in making choices about your treatment and care?	93.3
Satisfied with your assessment	73.7*	Got the help that mattered to you?	91.4
*completely or mostly satisfied		Have confidence in your therapist and their skills?	95.8

An evaluation of patient satisfaction with the IAPT for SMI services similarly reported generally high levels of satisfaction. The evaluation used a mixed method approach, consisting of surveys (241 IAPT service users, and 64 IAPT service non-users) and semi-structured interviews with 61 individuals strategically

sampled from across the sites who completed the survey. Overall, survey and interview participants were pleased with the way in which the therapy was provided, and their relationship with their therapist, and also felt that the service had impacted positively on their day-to-day lives.

The less positive aspects of people's experiences tended to be related to access issues and assessment processes, notably waiting times and the information and support offered during waiting times, as well as the structure, organisation and communication practices of the services. People who had not engaged with the IAPT for SMI service were more likely to report these negative experiences.

Based on the findings, twelve recommendations for improving the IAPT were identified:

1. Simplification of the referral process.
2. Clear information about what to expect from therapy, including: commitment required from service user, types of therapy on offer and choices people have about their therapy; timings and number of sessions; and endings and planning ahead for completion.
3. Information around, and promotion of, ongoing peer support available locally.
4. Information and clarity around diagnosis.
5. Reduction in waiting times and the provision of clear information about waiting times at the outset.
6. Good communication, information and support from IAPT service, and other services, agencies and organisations, during the waiting period.
7. Flexibility and accommodation of individual needs regarding the delivery of the therapy.
8. Good organisation, communication and 'customer service' throughout.
9. Strong improvement of therapeutic relationship through providing a validating atmosphere and non-judgmental approach.
10. Strong boundaries on the part of the therapist during group sessions.
11. Ease of access regarding practical considerations such as work / childcare commitments and travel problems.
12. Increased follow-up support

Transparency

The IAPT programme has produced high levels of transparency. The results are published every quarter – the outcome data from every IAPT service in the country (<http://content.digital.nhs.uk/iaptreports>). This level of information is rarely available to users of mental health services, going forward these data may help drive quality improvements and identify variability between services.

Staff training and development

One of the key challenges to the progress of the IAPT programme focused on the training and development of staff capable of delivering the evidence-based interventions. Staff can only be trained at a certain rate. Therefore, as part of the national roll-out plan, the decision was made to start by creating a small number of new services more or less at full capacity and get them to function properly. This approach also increased the chances of services following of the evidence-based protocol, following outcome monitoring processes, and providing staff good supervision.

Relapse rates

The lack of information regarding relapse rates is a weakness of the current IAPT system. Most IAPT services do not undertake a systematic follow-up process. This may partly be explained by commissioners emphasizing high numbers of patients accessing services and not identifying payment related follow up.

The original pilot sites did have a (nine month) follow up process. In Newham, the data indicated people were as well after nine months as they were at the end of treatment. In Doncaster, there was a small but significant drop-back, but they were still a lot better than when they started.

The Psychological Wellbeing Practitioner (PWP) role

Feedback from PWP's includes concerns that they are seeing clinical cases they're not trained for, they are reporting high levels of stress due to high workload demands and the lack of promotion options within IAPT programmes.

It is likely, these factors are contributing to a high turn-over rate of PWP's (22% per annum). This has implications across the system. Firstly, in terms of training and developing sufficient new staff to fill vacancies, and secondly, in regards to economic calculations.

One approach to filling these resource gaps has been to have low intensity services managed by non NHS providers, for example voluntary groups like MIND or Re:Think.

Weaknesses of IAPT

Although the programme appears to have been successful in delivering against most targets, Various reviews have highlighted a number of challenges:

- Waiting times – building adequate service provision (including number of services, and size and efficiency of workforce) to ensure access for all who need treatment within 28 days of first contact.
- Unmet need – addressing issues concerning equitable access to services where access is lower than expected among some population groups.
- Patient choice – increasing information on treatment options and ensuring that treatment plans are agreed by both patient and therapist.
- Treatment completers – undertaking further analysis to determine why performance against this KPI has dipped, to understand and address the factors that are critical in ensuring that patients complete treatment.
- Funding distribution process – ensuring that appropriate investments continue to be made in local IAPT services, to continue to expand capacity and assure quality in line with the overall financial expectations set out in the Spending Review.
- The IAPT legacy – IAPT is a strong brand within mental health services. However, it is a major challenge to ensure that the fundamentals of the programme and its quality standards are offered

- in all talking therapies services across all geographic regions. An accreditation process will help to ensure that the strong brand is maintained and that the legacy can be protected.
- Programme continuity – related to the above, recent system changes and reforms in the health system raise issues of stability and continuity and will require very careful handling in the transition process.

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