iapt
Improving Access to Psychological Therapies

DH Department of Health

IAPT three-year report

The first million patients

November 2012

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The first million patients

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At least one in four people will experience a mental health problem at some stage in their lives. This can place a significant burden on that individual's wellbeing, their family, the NHS and the wider economy. Recognising this, in February 2011 the Coalition Government highlighted its commitment to improving mental health in England through *No health without mental health*, a strategy that aims to achieve parity of esteem between mental health and physical health services.

In *Talking therapies: A four-year plan of action* – published at the same time, and in support of the overall strategy – the Government made a clear commitment to increasing access to evidence-based psychological therapies. In the 2010 Spending Review, the Government committed an additional £400 million over the next four years to 2014/15, and confirmed support for the Improving Access to Psychological Therapies (IAPT) programme, which was originally launched in October 2008. Since that time the IAPT programme has supported services and commissioners to ensure access to talking therapies for all those who need them, and has contributed to achieving very real improvements in the lives of people with anxiety and depression.

As this report indicates, at the end of the first three full financial years of operation (end of March 2012), more than 1 million people have used the new services, recovery rates are in excess of 45% and 45,000 people have moved off benefits. As a consequence, there are strong indications that the IAPT initiative is beginning to not only make a difference to individuals and their families but also to realise economic gains in terms of anticipated savings to the NHS and welfare system alongside increased tax contributions.

The report also indicates that, although the initiative has made tremendous progress, the job is not finished. Further work is required to continue expanding local services both in scale and scope and to make careful use of the very comprehensive data that is now beginning to be available on patient experience and other factors to improve the efficiency and effectiveness of delivery.

It is clear that there are further benefits to be gained from continuing to support increased access to good-quality, evidence-based psychological therapies and this remains a very clear government commitment. The report identifies a number of delivery challenges and, although this will not be easy, it is expected that these will be addressed.

Norman Lamb
Minister of State for Care Services

Foreword by the Chief Executive of the NHS

As this report indicates, the progress made since the inception of the Improving Access to Psychological Therapies (IAPT) programme in October 2008 is truly impressive. This is a further indication of the capacity and capability of the NHS and its partners to respond effectively in establishing new services focused on delivering evidence-based treatments. However, this report also makes it clear that more remains to be done to consolidate local services and realise the full benefits of the step change in investment and delivery of accessible, safe and effective psychological therapies in England.

I can confirm that the NHS Commissioning Board is fully committed to delivering the Government's ambition to improve access to psychological therapies. This will mean not only continuing to support local clinical commissioning groups and health and wellbeing boards in completing the roll-out of the adult programme, but also extending benefits to children and young people, and those with a severe mental illness, long-term conditions and/or medically unexplained symptoms.

Sir David Nicholson, KCB, CBE
Chief Executive of the English National Health Service
Chief Executive of the NHS Commissioning Board

1.0 Executive summary

The Improving Access to Psychological Therapies (IAPT) programme is a large-scale initiative that aims to increase significantly the availability of National Institute for Health and Clinical Excellence (NICE)-recommended psychological treatments for depression and anxiety disorders within NHS-commissioned services in England.

IAPT is fundamental to the implementation and success of the Government's mental health strategy, *No health without mental health.*[1] This cross-government outcomes strategy has committed in excess of £400 million over the four years to 2014/15 to further improve equitable access to psychological therapies.

IAPT is partway through roll-out. Progress to date has largely met, and has in parts exceeded, expectations. Key successes of the programme in the first three years include:

- treating more than 1 million people in IAPT services
- more than 680,000 people completing a course of treatment
- 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'[2] (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
- a session-by-session outcomes monitoring system, collecting data on 90% of contacts with service users
- training of a new, competent workforce of nearly 4,000 new practitioners, to deliver NICE-recommended treatments
- economic gains in terms of employment attainment and retention, with more than 45,000 people moving off sick pay and benefits[3]
- initiation of a major transformation project using IAPT quality markers to improve Child and Adolescent Mental Health Services (CAMHS).

1 HM Government (2011). No health without mental health: A cross-government mental health outcomes strategy for people of all ages, February.

2 An individual is said to be at caseness when their outcome score exceeds the accepted threshold for a standardised measure of symptoms. (Further detail is available in The IAPT Data Handbook, available from www.iapt.nhs.uk/services/measuring-outcomes/.)

3 IAPT key performance indicator performance data, available at www.ic.nhs.uk/statistics-and-data-collections/mental-health/nhs-specialist-mental-health-services

Over the next three years, in line with current commitments, it is expected that further progress will be made in increasing 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%. This will build on progress to date and will address the remaining challenges to ensure that the strategy outlined in *No health without mental health* becomes a reality and that *Talking therapies: A four-year plan of action*[4] is delivered.

Working to achieve these goals will require focus on:

- monitoring patient satisfaction, safety and clinical effectiveness
- training a further 2,000 additional practitioners in psychological therapies to meet service demand
- evaluating services to determine what practical models best deliver evidence-based services and how best to support sustainable investment
- expanding services to address local needs, including extending the scope of the programme to specific at-risk groups
- continuing the project to transform mental health services working with children and young people (CYP)
- being responsive to the needs of diverse and under represented communities
- ensuring that sufficient evidence-based services are provided throughout England by 2015.

Despite this clear focus and the good progress that has been made to date, as IAPT moves into a second phase new challenges have emerged. In particular the success of the initial phase of the programme in the provision of services to the adult population has dramatically increased referrals to such an extent that significant waiting lists have built up in a number of areas as the limited number of service providers struggle to keep pace with demand. Equally, as momentum has begun to build in relation to extending the scope of the programme to specific at-risk groups, high expectations have been established regarding delivery.

This report details the origins of the programme and highlights progress and successes after the first three full financial years of roll-out. It also outlines future requirements, particularly in meeting the financial commitments to 2015 in the Spending Review 2010 and political commitments outlined in the Coalition Agreement and other documents, together with plans to meet them.

4 DH (2011). Talking therapies: A four-year plan of action – A supporting document to No health without mental health: A cross-government mental health outcomes strategy for people of all ages, February.

2.0 Introduction

Mental health represents nearly a quarter of the burden of ill health in the UK and is the single largest cause of disability. One in four people in the UK will experience a mental health disorder at some point in their lives, with one in 100 people experiencing severe mental illness (SMI).[5] More recent estimates[6] assert that mental illness accounts for nearly 40% of all morbidity.

Good mental health is fundamental to our physical health, relationships, education/work and achieving our potential, and brings wide social and economic benefits to individuals and society.

Health gains for those who recover from common mental health problems are significant. Improved mental health and wellbeing is associated with improved physical health and life expectancy, better educational achievement and increased skills, reduced health risk behaviours, better relationships and overall improved wellbeing.

No health without mental health, the Government's mental health strategy, aims to:

- improve the mental health and wellbeing of the population and keep people well
- improve outcomes for people with mental health problems through high-quality services that are equally accessible to all.

Providing access to high-quality, evidence-based talking therapies is critical to the success of this strategy.

IAPT advocates that the following four principles are embedded within mental health services, and prioritises working towards:

- improved access to services
- clinical improvement and recovery
- improved social and economic participation
- increased patient choice and satisfaction.

5 Ibid.

6 London School of Economics (2012). How mental illness loses out in the NHS.

Dr Ali Parrish's experience

GP at Selsey Medical Practice, Selsey

The IAPT service in my locality has been a huge success. Its value has been widely felt by patients and GPs alike.

I hear GP colleagues saying that it's the single most positive change to their medical practice in the last 20 years and I echo this.

Our local service reaches out to the community and is always looking at ways to improve. It is continuously developing new evidence based interventions for people with anxiety and depression delivered 1:1 and in groups in a flexible way that means patients have real choice. They have filled a huge gap in need and are a force for good.

3.0 Programme development

3.1 Reviewing the evidence

In 2004, NICE conducted a systematic review of the evidence for the effectiveness of interventions for depression and anxiety disorders. This showed that cognitive behavioural therapy (CBT) was an effective first-line treatment for a large amount of common mental health morbidity, but that it was not readily available. The evidence also showed that CBT could produce impressive recovery rates, and in many cases better prevent relapse, compared with medication alone.[7]

In the same year a series of clinical guidelines were published that strongly supported the use of psychological therapies and CBT for depression and anxiety disorders.[8] NICE also recommended evidence-based, second-line talking therapies treatments for depression where CBT had been unsuccessful, but this was also in limited supply.[9] This series of publications followed the first NICE guideline that recommended CBT for schizophrenia,[10] which was widely accepted but which again was available in only a limited number of services.

3.2 Creating political commitment

On publication of the 2004 NICE guidelines, a group of economists and clinical researchers argued that an increase in access to psychological therapies would largely pay for itself by:

- reducing other depression and anxiety-related public costs, such as welfare benefits and medical costs
- increasing revenues through taxes from return to work and increased productivity.

Both academic[11] and popular[12] articles were published which were widely distributed and influenced the thinking of ministers, policymakers and the broader public. This initiative was further supported by the 'We Need to Talk' coalition, formed across a broad spectrum of

7 DeRubeis R, Hollon S, Amsterdam J, et al. (2005). Cognitive therapy vs medications in the treatment of moderate to severe depression. Archives of General Psychiatry 62(4): 409–416.

8 NICE (2004). Depression, Clinical Guideline 23 (replaced by Clinical Guideline 90 in 2009); NICE (2004). Anxiety, Clinical Guideline 22 (replaced by Clinical Guideline 113 in 2011).

9 Ibid.

10 NICE (2002). Schizophrenia, Clinical Guideline 1 (replaced by Clinical Guideline 82 in 2009).

11 e.g. Layard R, Clark D, Knapp M and Mayraz G (2007). Cost-benefit analysis of psychological therapy. CEP Discussion Paper No. 829, London School of Economics.

12 e.g. Layard R, Bell S, Clark D et al. (2006). The depression report: A new deal for depression and anxiety disorders. The Centre for Economic Performance's Mental Health Policy Group, London School of Economics; We Need to Talk Coalition (2006). We need to talk: The case for psychological therapy on the NHS.

interest groups including mental health charities, professional organisations, Royal Colleges and services providers.

In response to the NICE guidelines and the economic rationale, in 2005 political commitment and funding were secured to explore how best to increase the availability of evidence-based psychological treatments for adults with depression and anxiety. The IAPT programme was set up to pursue this ambition.

The programme began with two regional demonstration sites in 2006, which successfully tested and developed the care pathways and skills needed to deliver NICE-approved, evidence-based therapies. Supported by positive initial evaluation, the first wave of services began in October 2008 and thereafter a full national programme was rolled out.

3.3 The economic rationale

Political commitment to the programme has been strong, and the Government allocated over £300 million to the first phase roll-out of the programme in the 2007 spending review.

As part of the 2010 Spending Review, and in line with ministerial commitments such as those outlined in the Coalition Agreement and *No health without mental health,* a four-year plan for talking therapies[13] was funded, with a further allocation of over £400 million up until 2014/15.

The programme is expected to generate net savings in excess of £300 million by March 2015 through:

- NHS savings through reductions in healthcare usage
- Exchequer savings through helping 75,000 people move off welfare benefits
- economic gains to employers through reduced sickness absences.

By the end of 2016/17, a net financial benefit of £4,640 million[14] is expected as the provision and utilisation of accessible evidence-based therapies increases. This will be due primarily to prevention and early intervention particularly encouraging reductions in sickness absence.

13 DH (2011). Talking therapies: A four-year plan of action – A supporting document to No health without mental health: A cross-government mental health outcomes strategy for people of all ages, February.

14 DH (2011). Impact assessment of the expansion of talking therapies as set out in the mental health strategy.

4.0 The IAPT programme

4.1 IAPT aims

The overall programme goal is to ensure access to psychological therapies by March 2015 to all who would benefit from it. To do this, the programme aims to:

- complete the nationwide roll-out of IAPT services, ensuring equitable access to all population groups
- initiate a stand-alone programme for children and young people
- extend the benefits of talking therapies to those with long-term conditions (LTC) or medically unexplained symptoms (MUS)
- expand access to those with SMI.

In addition, the programme aims to build on the work undertaken in the first three years, including:

- monitoring patient satisfaction, safety, clinical effectiveness and other outcomes that new practitioners and existing, experienced staff achieve in clinical practice
- training large numbers of additional practitioners in psychological therapies to meet service demand
- evaluating services to determine what practical models best deliver evidence-based services and how best to support sustainable investments in present and future services
- expanding services to address local needs, including extending the scope of the programme to specific high-risk groups
- ensuring that evidence-based services are provided throughout England by 2015.

4.2 IAPT objectives

In interpreting the programme aims and developing a clear work programme, the IAPT Programme Board has identified the following objectives to be achieved by March 2015:

- secure sustainable and equitable access for at least 15% of the local adult population in need of effective evidence-based psychological therapies and a 50% recovery rate among those completing treatment
- develop and 'hardwire' a number of key IAPT quality standards within the Department of Health (DH) and NHS performance management frameworks, with a particular focus on care pathways, workforce integration, routine outcomes measurement, reporting, commissioning and employment support

- provide guidance and support to regional teams and other NHS and non-NHS colleagues as to how best to deliver services in line with these standards
- extend access to include children and young people, people with MUS, co-morbid mental and physical health LTCs, those with SMI and older people
- develop a systematic approach to assuring sustainability by using the opportunities within the outcomes and data capture processes to achieve significant system change, particularly in relation to contract currencies.

4.3 Service reach

Access to and use of talking therapies have increased since the programme started in 2008, but provision of services throughout England is still insufficient. In consultation with strategic health authority (SHA) colleagues, a range of experts and the DH central IAPT team, it was agreed that by 2015, IAPT services should be treating at least 900,000 patients annually, or 15% of the total estimate of 6 million[15] people in England with common mental health disorders.

This is based on the assumption that in any given population, of 100 people with depression and/or anxiety, only 50 will seek treatment; of those, only 25 will be diagnosed and equally distributed between anxiety and depression; and of those, 80% with anxiety and 68% with depression, or around 18 patients, will opt for psychological therapy. The figure of 15% therefore allows for a degree of local variation in performance and patient preference.

Each SHA in England agreed a share of the total estimated number of patients entering treatment, as set out in Table 1.

15 Derived from the Adult Psychiatric Morbidity Survey (2000).

Table 1: Estimated number of patients entering treatment per year, based on relative deprivation and assumed prevalence

SHA	Prevalence	Entering treatment by March 2015	'Cases' completing treatment by March 2015	Recovery rates by March 2015	Moving off sick pay and benefits by March 2015
East of England	684,797	100,800	67,200	33,600	2,800
East Midlands	431,814	63,562	42,375	21,187	1,766
London	1,018,112	149,863	99,909	49,954	4,163
North East	330,385	48,632	32,421	16,211	1,351
North West	1,004,581	147,872	98,581	49,291	4,108
South Central[1]	411,454	60,565	40,377	20,188	1,682
South East Coast	430,321	63,342	42,228	21,114	1,760
South West	613,546	90,312	60,208	30,104	2,509
West Midlands	568,463	83,676	55,784	27,892	2,324
Yorkshire and Humber	620,772	91,376	60,917	30,459	2,538
Total	**6,114,245**	**900,000**	**600,000**	**300,000**	**25,000**

Table 1 also shows the remaining key targets that have been set for each SHA:

- 66% of service users completing treatment, as estimated from key performance indicator (KPI) returns from 2008/09 to 2010/11
- recovery rates for those 'at caseness'[17] – 50% of those completing treatment
- a proportion of the national total of individuals moving off sick pay and benefits.

Once achieved, these service targets will allow access to evidence-based psychological treatments for 15% of patients with common mental health disorders, primarily anxiety and depression. Achievement will, however, require significant increases in local service capacity, both to address the issue of increasing demand and to expand services to those patients who are currently unaware of or unable to access services.

4.4 Equality

Equality and human rights are integral to equitable and inclusive IAPT services. One of the programme's aims this year is to further extend talking therapies to populations with low

16 Although responsibility for Milton Keynes has moved from South Central to East Mids regional leads, the move has not been officially agreed by DH. Therefore, for publications purposes, it still reports as South Central.

17 An individual is said to be at caseness when their outcome score exceeds the accepted threshold for a standardised measure of symptoms. (Further detail is available in The IAPT Data Handbook, available from www.iapt.nhs.uk/services/measuring-outcomes/.)

coverage. Equality objectives are embedded and implemented using the systematic collation and analysis of demographic data, the results of patient satisfaction surveys and partnership work with organisations that represent diverse communities.

The IAPT programme will consider that equitable access has been achieved when:

- the proportion of patients using IAPT services is in line with both prevalence and the community profile
- a diverse group of people choose to access psychological therapies to improve their mental health
- recovery rates are unaffected by age, race, religion or belief, sex, sexual orientation, disability, marital status, pregnancy and maternity, or gender reassignment.

Adam's experience

IAPT service user

My story started about 15 years ago after having a breakdown. I remember taking about a year to recover from the breakdown but was left with a fear of developing cancer. I managed to live with this fear but over the years the fear grew and grew. About two years ago, the fear was at its strongest – it would be in my mind from the moment I woke up until the time I went to sleep. Some nights I would not sleep at all; I would just worry about which organ or part of my body would have cancer. I would check and prod myself constantly to feel for lumps if I had any kind of ache or pain. I got to a stage where I was wondering if I could spend the rest of my life feeling this way. Eventually I went to my GP to find out if anyone could help me.

The first contact I had from Health in Mind, an IAPT service, was a letter informing me I would be receiving a phone call to have a telephone assessment. A few weeks after the assessment I started my sessions.

I felt very anxious about the sessions at the start because it felt strange talking to a stranger, and I was quite tearful, which again was difficult at the start. Talking to my therapist became easier and after a couple of weeks we began to put together a plan of how to manage my phobia. She made me aware that there was no cure for a phobia but it could be managed, and together we made a plan. After a few more months we set a date by which time I would be able to manage my phobia by myself. It took me six months from Health in Mind first contacting me to my being able to manage my phobia alone. So far I have been able to control my phobia, but some days have been very difficult. The difference now is that I have the methods to manage my thoughts. Health in Mind has taught me how to manage my thoughts instead of my thoughts controlling me. I would highly recommend Health in Mind to anybody needing behavioural therapy, but you must help yourself too.

5.0 Benefits and performance

The first three years of the IAPT programme have delivered measurable success and benefits in the following areas.

Key **health and economic gains** directly attributable to the programme in the first three years include:

- treating more than 1.134 million people in IAPT services
- more than 683,000 people completing a course of treatment
- recovery rates in excess of 45% and approaching those expected from the randomised controlled trials that generated the initial NICE recommendations
- nearly 250,000 'cases'[18] (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
- a session-by-session outcomes monitoring system, collecting data on 90% of contacts with service users
- training of a new, competent workforce, to deliver NICE-recommended treatments
- economic gains in terms of employment attainment and retention, with more than 45,000 people moving off sick pay and benefits[19]
- initiation of a major transformation project using IAPT quality markers to improve CAMHS.

Designing and delivering a competently **trained workforce** was fundamental in developing additional capacity to deliver evidence-based talking therapies services.

The **creation of an inclusive and practical dataset** was particularly critical in implementing the first wave of services and in allowing the programme to measure and calculate progress and outcomes accurately and to continue to justify investment.

18 Ibid.

19 IAPT KPI performance data, available at www.ic.nhs.uk/statistics-and-data-collections/mental-health/nhs-specialist-mental-health-services

5.1 The dataset

IAPT has created an extensive dataset and services have locally collected data over the first three years of the programme on people who access services, the treatments provided and the outcomes achieved. Seven key performance indicators, collected quarterly from primary care trust (PCT) commissioners, are publically available and designed to be used to baseline service performance and inform the evidence base for continued investment. In addition, the dataset allows the programme to:

- establish a profile of service performance that is transparent to patients, service providers and commissioners
- encourage and inform patient choice
- help services to manage their clinical resources better
- advance service improvements by providing meaningful management information to service leads and other key decision makers.

The IAPT programme's robust dataset is based on patient-reported outcomes, which are routinely collected and recorded at each clinical session. All services are expected to achieve – and for the most part have achieved – very high levels of data collection (in excess of 90% in most cases). This has created a level of insight and knowledge on clinical outcomes that is far superior to previous attempts to collect data in psychological therapies and enables robust evaluation of service provision. For example, analysis undertaken in February 2011 showed that high overall recovery rates were associated with good use of stepped care models, in line with NICE guidelines. Further data analysis will continue and will be fed back into the system to ensure constant evidence-based evolution.

The comprehensive dataset also allows performance to be routinely measured against the established KPIs. The KPIs are based on numbers of patients accessing IAPT services and recovery rates. This is discussed in more detail in section 5.3, 'Calculated health gains'.

In April 2012, the IAPT data standard was approved by the NHS Information Standards Board as a nationally mandated data standard. Data is now collected centrally on a monthly basis from over 200 service locations. This additional dataset has greatly expanded service insight and will be publicly available during 2012/13 and will be used to improve services.

5.2 Trained workforce

Insufficient numbers of trained therapists to deliver talking therapies is a considerable barrier to access. By March 2015, an expected 900,000 people will be using IAPT services annually. An estimated additional 6,000 therapists are required, including both high-intensity therapists and the new psychological wellbeing practitioner (PWP) role, which provides

low-intensity, high-volume therapy. By July 2011, more than 3,400[20] new therapy workers had successfully completed training; and a further 538[21] new trainees entered training in the academic year 2011/12. In addition, a number of high-intensity therapists have also completed non-CBT training, to increase the range of treatment options that can be provided within IAPT services. Supervision capacity also continuously increased between 2008 and March 2012.

IAPT services are delivered by a workforce of both experienced and newly trained staff. The more experienced staff have an essential role in treating complex cases, as well as providing supervision of trainees and recent graduates. Initially, IAPT focused particularly on training CBT therapists, as this has the widest indication in NICE guidelines and had the largest deficit.

Towards the end of the first phase of the programme, the training programme was extended to include four new therapies that are recommended by NICE for depression (but not anxiety disorders): interpersonal psychotherapy; counselling for depression; couples therapy for depression; and brief dynamic interpersonal psychotherapy. Around 30% of the high-intensity therapists in the IAPT workforce are able to deliver these non-CBT therapies. This extended training programme followed published national curricula that are based on the competencies required to deliver the therapies correctly.

To meet the requirement of training the balance of an additional 2,400 therapists, plans are being implemented from the 2012/13 financial year to continue to increase CBT capacity. The increase in the number of therapists also includes substantial investment in non-CBT treatments and supervision. Since training packages were developed in 2010, more than 400[22] high-intensity therapists have been trained in the new modalities of therapy that have been approved to treat depression. A further 400[23] trainees are expected to be trained over the course of the present academic year (2012/13).

20 Data supplied by SHA workforce leads and IAPT regional leads.
21 Ibid.
22 Ibid.
23 IAPT (2012). Guidance for commissioning IAPT training 2012/13, July.

Ashley Snowdon's experience
PWP, Teeside IAPT Service

Working as a PWP in Teesside IAPT has been challenging and rewarding over the last few years. Since completing my training, I have seen over 200 people, some with relatively complex problems who have never accessed mental health treatment before, for whom brief interventions have made a huge impact on their functioning. The range of problems clients have presented with has been surprisingly broad, and has given me excellent development opportunities as well as developing my confidence as a clinician. Teaching people CBT-based skills has meant that they have been able to take control of their own problems and are more able to manage them in future. I have often found that people integrate CBT skills into their lives and then come back and report that they have been teaching them to their friends and family! I have also been closely involved in a pilot scheme working with drug and alcohol users, who have responded really well to the short-term, time-limited work, because they can see quicker results and seem to feel empowered by the guided self-help approach.

5.3 Calculated health gains

The major health and wellbeing gains from access to talking therapies are seen by individuals who recover from mental illness and their families. More than 1.1 million people entered in the first phase of the programme, with more than 250,000 cases completely recovering.

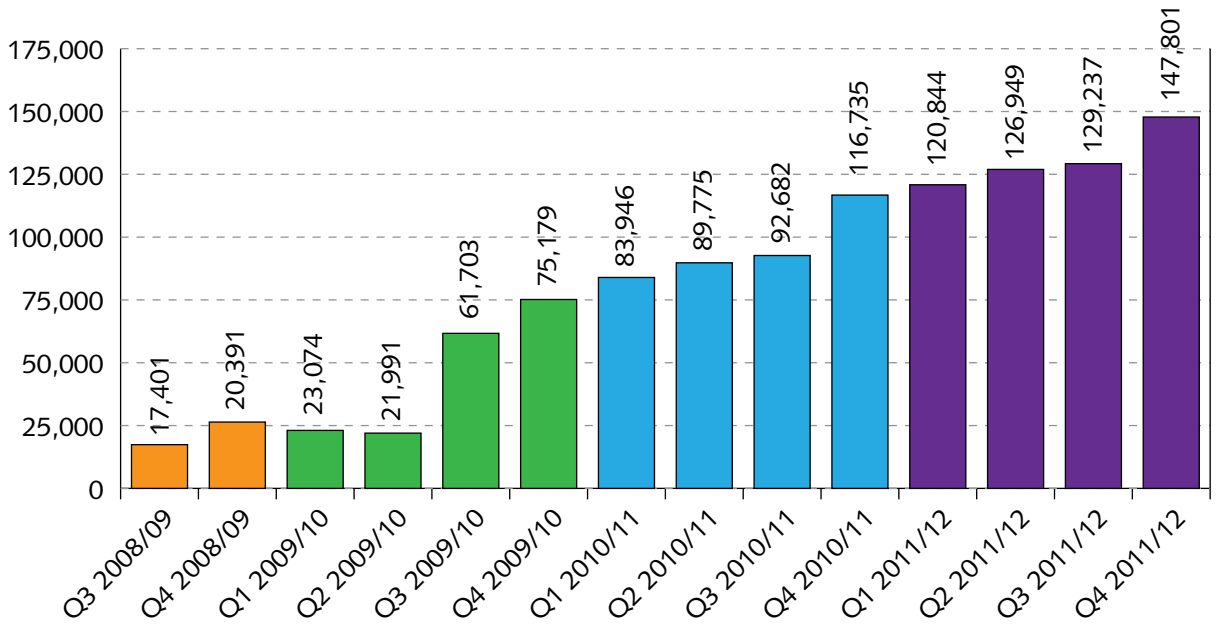
This section highlights three of the important KPIs as evidence of progress within a typical NHS IAPT service and of benefits for service users: access rates, numbers of people completing treatment and recovery rates are analysed using the data that has been collected. Data covers the period from the initiation of the first wave of sites in October 2008 (Quarter 3, 2008/09), through the 'ramp-up' period, to the completion of the first three full financial years of operation (up to and including Quarter 4, 2011/12).

5.3.1 Access rates

Access rates overall have steadily improved as new services have begun and as existing services have increased both their capacity and their visibility in local health economies. Annual access targets have been met or almost met. By March 2012, continuing increases in access rates were evident, with IAPT services treating an average of 9.68% of the prevalence of common mental health problems in their local communities. This equates to nearly two-thirds of the full roll-out target of 15%, to be achieved by March 2015.

However, some services do not have representative access from their local communities with regard to age, ethnicity and other factors. Data to accurately monitor access across these and other 'protected characteristics' has been collected since April 2012, and equitable access across all population groups is being monitored via the equalities workstream from April 2012 onwards.

Figure 1: Number of people entering treatment quarterly, from Q3 2008/09 to Q4 2011/12



Tom's* experience

IAPT service user

'Before using the service I was in a very dark place and felt lost. My therapist helped me to look at and think about things in a different way. My therapist helped me with my day-to-day life. After my sessions, I came away feeling reassured and stronger to carry on with my recovery. I don't know what I would have done without this help. Thank you for the invaluable service.'

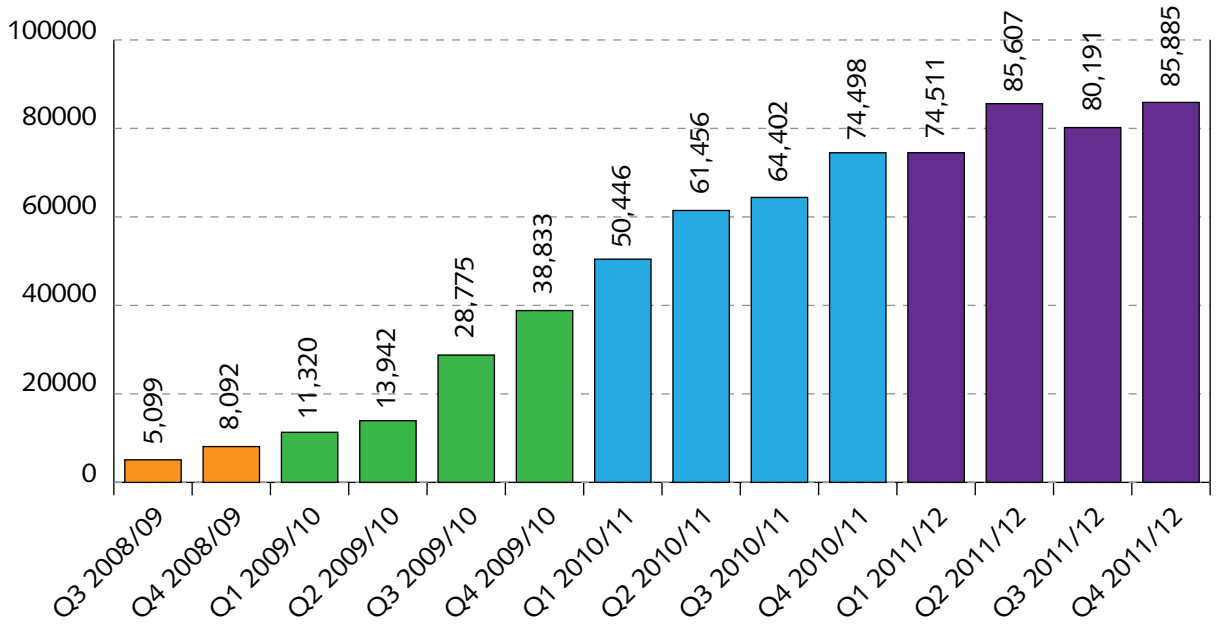
(*Not his real name).

5.3.2 Completed treatment

Although the total number of people completing courses of treatment has increased as service provision has grown, the percentage of people completing a course of treatment has decreased. The programme has focused on ensuring as far as possible that individuals complete courses of treatment in the interests of continuity of care and so that they realise important benefits, for example increased relapse avoidance.

The KPI for completing treatment was set at 66%. This target was reached in the second half of 2010, however, by the end of March 2012, 60% of service users were completing treatment. Early analysis suggests that as the scale of service provision has increased, this target has become more challenging to reach. The IAPT central team is currently exploring this issue further so it can work towards ensuring that completed treatment rates reach the target by March 2015.

Figure 2: Number of people completing treatment courses, Q3 2008/09 to Q4 2011/12



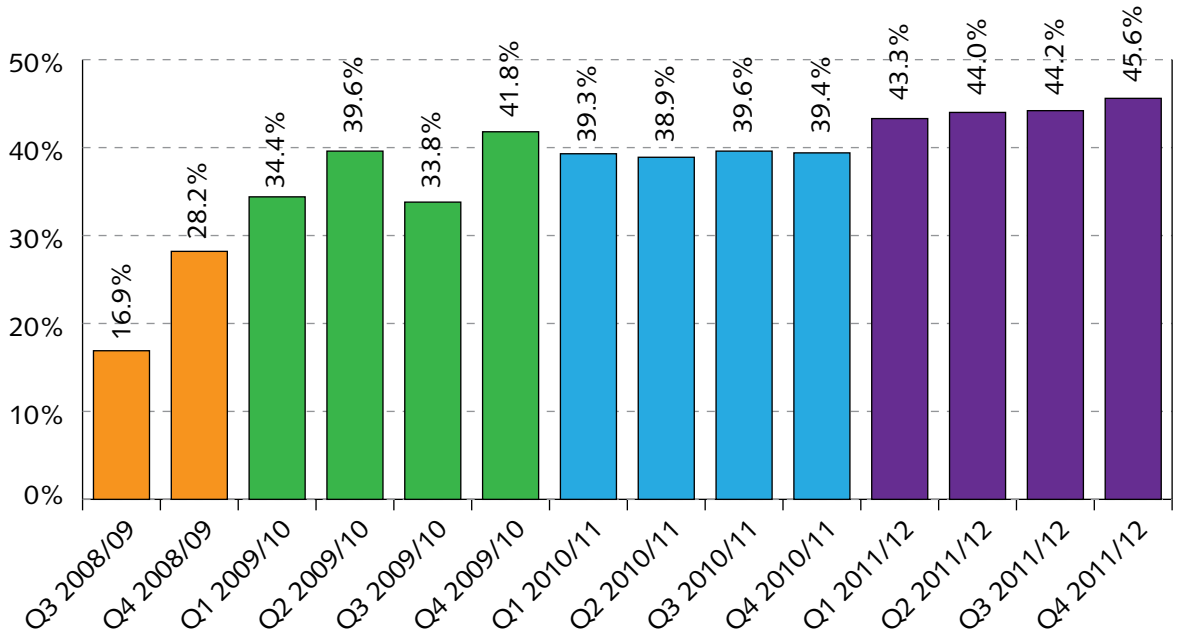
5.3.3 Recovery rates

Recovery rates have steadily improved from 17% to over 45% over the first three years of the programme, indicating that services are becoming increasingly effective. This is in line with expectations derived from the pilot sites and early implementers in phase one of the IAPT programme between October 2008 and March 2009.

Recovery rates have increased each year, with the highest level of recovery gained in Quarter 4 of 2011/12. This reflects the programme's continual drive to improve service provision and to ensure that the information from analysis of the data is fed back into the system for further development and improvement.

It is also important to note that many patients who do not fully recover still achieve worthwhile benefits and are able better to recognise and manage their illness by using techniques and tools learnt in therapy.

Figure 3: Recovery rates, Q3 2008/09 to Q4 2011/12



5.4 Economic gains

The original justification for the programme was strongly based on the rationale that the service would pay for itself, and indeed make net gains.

Full roll-out of the programme would enable savings in the NHS in the following key areas:

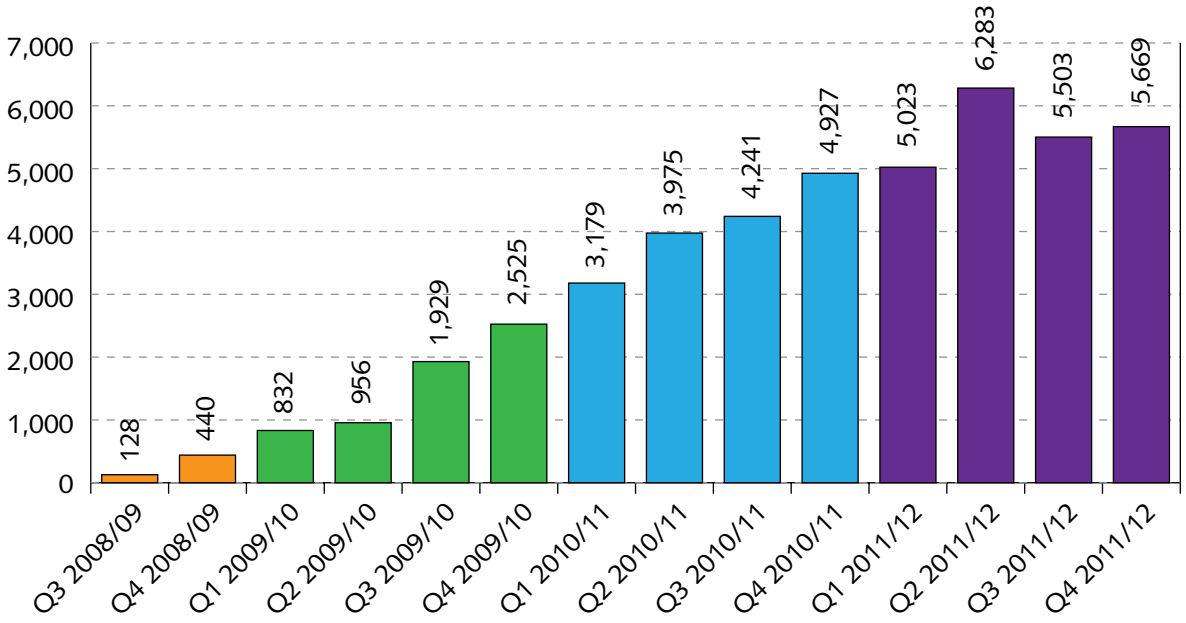
- reduction in healthcare usage by those who recover, estimated to be around £272 million by 2016/17[24]
- reduction in long-term repeat prescriptions for antidepressants due to the greater enduring effect of talking therapies compared with medication
- reduction in GP appointments
- reduction in outpatient appointments and procedures
- reduction in inpatient bed days.

Further economic gains are expected both to the Exchequer, in terms of people retaining employment or moving off welfare benefits, and to employers, who benefit from a reduction in sick days by talking therapies service users.

24 DH (2011). Impact assessment of the expansion of talking therapies as set out in the mental health strategy.

The programme has made good progress in helping people move off sick pay and benefits, and this has continued to increase in each year of the programme, with more than 45,000[25] people to date no longer receiving sick pay and/or benefits. This continues to justify ongoing investment and provides a strong argument for additional investment. Recent, more detailed evaluations[26] have indicated the overall value of access to good quality employment advice and co-ordination within IAPT services.

Figure 4: Number of people moving off sick pay and benefits, Q3 2008/09 to Q4 2011/12



25 IAPT KPI performance data, available at www.ic.nhs.uk/statistics-and-data-collections/mental-health/nhs-specialist-mental-health-services

26 Office for Public Management (2011). IAPT employment support services in London – Assessment of the economic impact. Available at http://base-uk.org/sites/base-uk.org/files/%5buser-raw%5d/11-06/wfw_esw_economic_impact_report_final_v09.pdf#

Russell Smith's experience

Director Regional Field Operations – London, DHL International (UK) Ltd

Wandsworth IAPT Employment Service has provided support to one of our employees at DHL for a number of months, which proved to be invaluable. We have many forms of employee assistance programmes but the employment specialist was able to build a relationship with all parties, which was instrumental in a successful conclusion. Through talking with the specialist, I was able to able to improve my understanding of mental health issues, which I found very valuable. At all times the relationship between all parties remained objective and friendly and it was a pleasure to work with the specialist and I would definitely do so again. We are currently in discussions about further support for our employees.

(This is Mr Smith's opinion only).

6.0 Completing roll-out

The above performance levels demonstrate that the programme is on track to meet the assumptions made in *Talking therapies: A four-year plan of action*; that is, by March 2015 sufficient capacity will have been established to:

- treat 900,000 people annually, of whom 600,000 will complete treatment and 300,000 will recover
- correct the current unequal access nationally across some populations, particularly among black and minority ethnic groups, older people, and other groups defined as having protected characteristics
- continue to expand the CYP programme to transform existing CAMHS.

By March 2015, the programme will have seen a cumulative total of:

- 3.2 million people receiving advice or a course of therapy
- 2.6 million people completing a course of therapy
- up to 1.3 million of the above (50% of those completing treatment) moving to measurable recovery.

The programme is now focusing on supporting roll-out by March 2015, including extending access to specific at-risk groups and children and young people. Each of these workstreams is supported by a range of expert professionals, service users and carer advisers, with specific functional task and finish groups and networks.

This work is presently being undertaken by the IAPT central team, which has been set up to oversee the programme during 2012/13 through a short-term increase in central and SHA-level resources. The current work plan is focusing not only on continuing the roll-out programme but also on making substantial progress in the areas of enhanced scope and achieving effective transition into the new system architecture that is being established as part of the Health and Social Care Act 2012.

6.1 Technical development workstreams

6.1.1 Outcomes and informatics

Outcomes and informatics (O&I) is a core workstream of the programme and provides advice and guidance primarily in areas connected to best practice, maintenance of the IAPT data standard (ISN 1520), expansion of the IAPT outcomes framework and reporting arrangements for projects that are targeting improvements for new groups of service users.

A key characteristic of an IAPT service is routine outcomes measurement. This is achieved by therapists working in conjunction with patients to record and track scores on clinical measurement tools (questionnaires) at each appointment session. These scores can be used to demonstrate the effectiveness of treatments offered and form a central feature of the therapeutic relationship. For patients to see and understand their progress through their episode of care, it is important that scores are collected regularly and that IT systems are able to provide reports at each patient session. Up-to-date information on an individual's progress should be readily available so that it can be used as an aid for collaborative decision making and to help IAPT workers to identify appropriate targets for intervention.

Routine outcomes measurement is also central to improving service quality and accountability. Following the implementation of the IAPT data standard, IAPT service providers are now mandated to submit patients' clinical records to the NHS Health and Social Care Information Centre. This data is transferred securely, anonymised and aggregated as the basis of publicly available management reports on the overall performance of the service. This enables transparency and therefore facilitates patient choice and allows trends to be identified to inform investment and service improvement decisions at local, regional and national levels. For example, specific reports for different groups of patients focusing on recovery and access rates can be used to monitor equitable access to IAPT services. This will allow follow-up action, and experience to date has shown that the biggest gains in access and recovery are typically among those groups that have experienced exclusion in the past.

6.1.2 Workforce and education

The workforce and education workstream oversees the effective implementation of plans at SHA level to increase the psychological therapy workforce through commissioning and recruiting to appropriate education and training courses.

The completion of the expansion of the IAPT workforce programme is vital to ensuring adequate capacity in IAPT services to meet the anticipated demand for psychological therapies to treat depression and anxiety disorders effectively by March 2015.

This workstream liaises with DH and SHA workforce colleagues and IAPT course leads to ensure that IAPT training commissions are realised. All IAPT training courses are accredited, and work continues to embed the accreditation processes across the six professional bodies that accredit them.

The commissioning of IAPT training for the academic year 2013/14 represents the final year of a three-year agreement within the overall multi-professional education and training (MPET) budget to fund IAPT training. The workstream will support the development of investment plans for 2013/14 so that this resource can be used to expand the workforce further, to provide greater treatment capacity and to increase the range of NICE-approved psychological therapies available through IAPT services, thus increasing patient choice.

This workstream also supports IAPT development projects to ensure that the workforce is trained to reflect the changing needs of IAPT services. The adaptation of existing courses and the addition of new modules to enable IAPT therapists better to support older people and people with LTCs and MUS are in development and testing is under way. Work to develop professional competencies and training packages is also under way in conjunction with the SMI workstream.

Mapping of the IAPT workforce is in hand. Census data is becoming available and analysis is due for completion prior to publication in December 2012. Work is also continuing with the Centre for Workforce Intelligence to understand the make-up of the IAPT and wider psychological workforce, to support possible future regulation.

A review of the PWP training materials and curriculum will start in autumn 2012, with updates due to be published in March 2013.

6.1.3 Payment by results

The mental health clustering model was mandated in 2012 as the currency for mental health services, excluding IAPT services at that time. This seeks to make payments for defined episodes or packages of care, giving differential pricing for a range of needs (a payment by activity).

An alternative currency model for IAPT services is being piloted during 2012/13, using the recently enhanced dataset to incentivise improved outcomes rather than simply activity. The model seeks to match care to desired outcomes, i.e. rather than balancing demand and capacity, maximising the number of patients treated or paying for resources actually used in treatment, it seeks to incentivise increased equity of access and maximise the number patients who recover, as well as increase the number who are satisfied with services, including their treatment options.

A total of 24 pilot sites dispersed across England providing IAPT services volunteered to be involved in the pilot. They include NHS, private sector and third sector providers. Data capture is for nine months; it started on 1 April 2012 and will continue until 31 December 2012.

Analysis will be undertaken in early 2013 on the data collected. This information will be fed back to commissioners, as well as the wider mental health payment by results (PbR) system currently being established, to suggest a consistent pricing model for all IAPT services. This model will align commissioners' costs to outcomes and will act as a template that commissioners can adopt or adapt to local need, while still maintaing consistency in payments throughout the country.

6.1.4 Commissioning and provider development

The commissioning and provider development workstream is focusing on improving communications and understanding between the overall IAPT programme and key decision makers in the new system; this includes clinical commissioning groups (CCGs) in particular. In order to achieve this overall objective, this workstream is working with colleagues from the Joint Commissioning Panel for Mental Health[27] and the SHA mental health leads on developing a mental health commissioning pack. This will be an interactive tool for GPs, commissioners and users alike, accessible via an online portal. In addition, this workstream is leading on reviewing the model specification for adult IAPT services, minimum quality standards and accreditation requirements. Advice in each of these areas will feature in the commissioning pack.

In addition, the workstream has provided assistance to the central DH team leading the Any Qualified Provider initiative, which has been introduced to increase patient choice, and supporting SHAs and local commissioners in rolling this out across selected primary care psychological therapy services.

Emma's experience
IAPT service user

The support and advice I was given during my 'step-by-step' sessions have given me the strength, motivation and self-belief to work through my mental health issues head on. I was provided with a safe environment, free from judgement or pressure, where I felt listened to and understood. 'Step-by-step' played an important role in my journey back to good health and happiness, enabling me to now lead a fulfilling and enjoyable life.

6.2 New service development workstreams

In March 2012, IAPT extended its scope and added new service development workstreams: LTCs/MUS, SMI, older people, equalities and CYP. CYP IAPT is discussed further in chapter 7.

6.2.1 Long-term conditions and medically unexplained symptoms

The LTC/MUS workstream has been added to the programme to extend the benefits of improved equitable access to psychological therapies to people with LTC and/or MUS.

In February 2012, 15 services were selected as IAPT LTC/MUS pathfinder sites. They started work in April 2012. These sites are exploring and further developing the organisational, economic and quality arguments for increased integration of psychological support for

27 www.rcpsych.ac.uk/policy/projects/live/commissioning.aspx

people with LTC and/or MUS. Current evidence on training competencies is being reviewed to develop curricula for an effectively trained workforce.

Initial evaluation of the pathfinder sites is due in March 2013. It is expected that the report will provide further evidence to support improvement in access to psychological therapies for this group of patients and, if widely adopted and effectively implemented, will contribute to improved quality and reductions in long-term costs for the NHS.

6.2.2 Severe mental illness and personality disorders

The SMI workstream has been added to the programme to extend the benefits of improved equitable access to psychological therapies to people with SMI, psychosis, bipolar disorder and personality disorder (PD). The project will adopt a phased approach, with an initial developmental phase.

In November 2011, a large-scale conference was held to launch the SMI and PD workstream. This established a broad level of engagement and support among service commissioners, providers and service users and provided the momentum for a successful bid against the 2012/13 SHA bundle allocation for one-off funding to explore current good practice.

In August 2012, a search began for evidence from current service models that optimise access to psychological therapies, support patient choice and recovery, and provide insight on data capture requirements and workforce competencies.

With effect from October 2012, this workstream began to work closely with a number of secondary care mental health service 'demonstration sites' involving local commissioners and providers, to document the benefits of increased access to talking therapies for SMI and PD. This approach has a clear focus on the development of patient-reported outcome measures for SMI and PD, to identify gaps in current approaches and develop more clinically effective, acceptable, replicable and affordable care pathways.

August 2012 also marked the beginning of the process to appoint an evaluation agency, and it is expected that by February 2013 a report of the demonstration sites will be available. The IAPT programme will continue to support the sites until October 2013 in developing a dataset and promoting exemplar practice in the area of psychological therapies.

Analysis of the demonstration sites will provide detail on workforce profile and education needs, and may inform extensions to the current IAPT dataset (to ensure that it includes data that is relevant to SMI and PD treatment and commissioning). A report will be produced in support of the demonstration site findings, to inform the commissioning cycle for 2014/15.

6.2.3 Older people

The four year action plan for talking therapies clearly states the need to address the under-representation of older people (64 plus) using IAPT services across England. The analysis of outcome data highlights a discrepancy between the number of people accessing IAPT services and estimated prevalence rates in national surveys.

Age is a protected characteristic and the Equality Act 2010 defines a duty associated with it. It is an important driver for IAPT as it places an obligation on public bodies to demonstrate a positive approach to addressing this inequality.

The national programme via the four-year action plan is committed to addressing this gap and ensuring psychological services increase access rates for older people. The following measures and activities have been identified to deliver on this agenda:

- the appointments of a national adviser and project manager on older people
- setting up an expert reference group to link with clinicians, professional bodies and representatives of older peoples organisations
- work collaboratively with the LTC workstream to enhance work on older people through the LTC pathfinder sites
- support the needs of carers and specifically carers of people with dementia, with commissioning guidance and possible support for new online CBT provision.

Understanding the data on local populations including the diverse makeup of the older community within their localities is essential to measuring positive outcomes for this client group. More work will be conducted in this respect to support access into local IAPT teams.

6.2.4 Equalities

The equalities workstream is working to extend access to populations who currently have lower rates of access than expected. This workstream aims to achieve access rates and recovery rates that are unaffected by age, race, religion or belief, sex, sexual orientation, disability, marital status, pregnancy and maternity, or gender reassignment.

An equality reference group to encourage good practice across the NHS IAPT projects is supporting this workstream. A key output will be updated practice guides that reflect on how local teams can promote better responses to the needs of individuals from the protected characteristic groups. Data systems and associated guidance are also being aligned to capture information on diverse populations and their use of IAPT services, to inform effective equalities management strategies.

The equalities advisory group are providing independent guidance to ensure equalities are embedded in all workstreams in the IAPT national programme in line with local demographics and prevalence. Funding to promote community based access projects for groups with protected characteristics, is also being developed to promote good practice in this area"

6.3 Programme challenges

Although the programme has been successful in delivering against most targets so far, there is still much work to be done. A review of the programme midway through 2012/13 has identified the following key 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.

The IAPT work programme for 2012/13 is designed to progress as far as possible an effective approach to these challenges and ensure that the programme is in a sufficiently robust position, with support from key decision makers in the new system, to achieve successful transition.

7.0 Children and young people

7.1 The beginnings

In addition to the new projects described above, *Talking therapies: A four-year plan of action* also included the Government's intention to extend IAPT to children and young people. This part of the programme, in terms of ensuring extended scope, is described in detail, and a similar approach is being developed both for SMI and PD and for LTCs/MUS.

Poor mental health in early years and adolescence can lead to significant inequality and poorer mental health outcomes throughout life. Of those adults with severe mental health disorders, 50% present symptoms by the age of 15, and almost 74% by the age of 18.[28]

Currently in England:

- 9.6% of children aged 5–16 have a diagnosable mental health disorder
- 5.8% of 5–16-year-olds have conduct disorder
- 3.7% of 5–16-year-olds have an emotional, anxiety or depressive disorder[29]
- 14% of 16–19-year-olds have a diagnosable mental health disorder[30]
- a further 10% of 16–19-year-olds have significant problems or risk factors that indicate vulnerability to developing a mental health disorder.

The CYP IAPT project has been designed to meet the needs of children and young people in conjunction with the systems and services that surround them. Children and young people have different needs to adults and the following factors were considered when designing the project:

- the developmental and social needs of children and young people, the way in which they present to services and the importance of family and educational settings
- referral and pathway structures
- commissioning structures and the roles of the NHS, the local authority and the voluntary sector
- the business need (early intervention can improve outcomes for children and young people in terms of social functioning, e.g. the ability to participate in school, or in work,

28 Kim-Cohen J, Caspi A, Moffitt T, *et al*. (2003). Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective-longitudinal cohort. *Archives of General Psychiatry* 60: 709–717.
29 Meltzer H, Gatward R, Goodman R and Ford T (2000). The mental health of children and adolescents in Great Britain, Office for National Statistics.
30 Ibid.

can alter the trajectory for those who may otherwise develop severe and enduring mental health problems in later life).

The CYP IAPT project is building on the wide use of psychological therapies in CAMHS but has concentrated on changing services to focus on access and outcomes.

The project is ambitious and challenging both in pace and scope. In its first year, the project:

- moved from the initial plan to develop a national curriculum for two therapies and service development
- created a structure to deliver training and support service change
- developed a dataset, measures and national collation system
- began work on accreditation.

The speed with which the project has progressed has only been possible due to support from the CAMHS community, higher education institutions (HEIs) and children and young people's groups.

7.2 Project overview

The project aims to transform CAMHS tiers 2 and 3 psychological therapy interventions, to improve access in line with IAPT quality standards. The project will use the IAPT programme's evidence-based practice, case management and routine outcomes monitoring, but has an extra emphasis on participation by young service users.

Young people have been involved in the project design from its conception at both national and local level. The mental health charity, YoungMinds supported young people to contribute to project planning and interviewing applicants to join the project. Applicants joining the project were asked to demonstrate their commitment to involving young service users, and this is monitored by the project.

CYP IAPT service user's experience

Members of Article 12, the Young People's Participation Group at Oxford Health NHS Foundation Trust, aged 17 years

The whole project is about collaboration. It's not them treating us; it's about setting goals as a partnership and working together to get the best results possible for service users and professionals. Like we are all reading from the same page of the book.

It's a big change for everyone but it's a good one. We're making professionals more aware that they can involve the young people they treat in their care.

7.3 Year one – 2011/12

Following consultation with a wide range of professionals and with young people, the project established a CYP IAPT National Curriculum to deliver training in two therapies: CBT for anxiety and depression, and parenting for 3–10-year-olds with conduct disorder; and transformational leadership. CAMHS partnerships working with HEIs across England were invited to bid to become CYP IAPT learning collaboratives through a competitive process.

Successful sites demonstrated a partnership between HEIs and CAMHS partnerships (defined local partnerships of statutory and voluntary sector providers and commissioners) working together to deliver training to supervisors, therapists and service managers. The partnerships committed to improving access and participation, and to introducing session-by-session outcomes monitoring by all professionals working in targeted and specialist services that were part of the CYP IAPT project, not just those being trained by the project. The learning collaborative as a whole signed up to working with the project (subject to quality assurance) to 2015, with partnerships agreeing to support and mentor new partnerships joining in subsequent years to share the learning and experience of service transformation.

Three learning collaboratives were appointed: London and the South East; Oxford/Reading; and Salford. The collaboratives supported a total of 18 partnerships with services covering 18% of the population aged 0–19 years. Courses for service managers and supervisors began in November 2011 and the first cohort of trainee therapists enrolled in January 2012.

CYP IAPT trainees experience
CBT trainee, Salford

It's hard going but worth every minute. I'm a different clinician now – much more effective.

Parent Training trainee, Salford

The video supervision is intensive, but I can't believe how much I've learnt from it.

A CYP IAPT dataset was developed that took account of the status of the CAMHS minimum dataset, identified a series of validated measures for use in sessions and produced guidance for therapists and supervisors. The project commissioned a central data collation and analysis function, but worked with a range of providers to develop local collation methods to encourage a plurality of suppliers.

The dataset and measures have been adopted by the CAMHS PbR project, creating synergy between strategic developments and further reinforcing the need for services to be ready for the change in emphasis in commissioning to focus on outcomes as much as outputs.

Participation in CYP IAPT will help services to deliver a high-quality, outcomes-focused service which can demonstrate that it meets service users' needs.

Practitioners using routine outcome monitoring measures experience
Practitioners trained in year one

A lot of young people who have used these tools have reported that they feel valued and involved in the therapy process.

[Use of the measures] helps build a shared understanding of the problem on which to base a shared formulation and rationale for treatment ... it supports collaborative working with young people and families and facilitates open conversations around different areas.

7.4 CYP funding

The 2010 Spending Review announced the expansion of talking therapies to include those below working age, and £8 million a year was committed to improve access to psychological therapy services for children and young people in 2011/12 to 2014/15.

In February 2012, the Deputy Prime Minister announced further funding for child mental health services, including the CYP IAPT project, of up to £22 million in total for 2012–15. The additional funding has been given to:

- extend the geographic area covered by CYP IAPT
- extend the number of therapies offered through CYP IAPT
- create an e-Portal to include:
  - interactive e-learning modules for professionals working with children and young people, including NHS clinicians such as GPs and paediatricians, staff in universal settings such as teaching staff, social workers, police and probation staff and faith workers, and counsellors and supervisors working in a range of educational and youth settings. This will help these professionals to support children and young people when they are experiencing mental health issues
  - a blended learning e-curriculum for CYP IAPT
  - exploring whether e-therapy options can be delivered to children and young people, such as computerised CBT.
  - e-learning for NHS clinicians, staff working with children and young people in universal settings, and school/youth counsellors
  - a blended learning e-curriculum for CYP IAPT

- exploring further options for e-therapies.

7.5 Year two – 2012/13

In February 2012 the project advertised for two further learning collaboratives, together with additional partnerships to join the existing learning collaboratives. Collaboratives from the South West and North East and Yorkshire, covering three and six CAMHS partnerships respectively, were announced by the Minister for Care Services at the first CYP IAPT National Conference in July 2012, along with a further fifteen new partnerships joining the first three learning collaboratives. By the end of 2013, services covering 34 % of the population aged 0–19 years with have been through the CYP IAPT service transformation process.

In the second year of the CYP roll-out, the programme will:

- extend the choice of therapies to include systemic family therapy and interpersonal psychotherapy
- develop a 'basic IAPT' training course as part of all practitioners' continual professional development, across all CYP IAPT sites
- develop accreditation systems to ensure that individuals and courses can be accredited by recognised bodies and that services can demonstrate quality, access and outcomes whether through accreditation or other mechanisms
- assist in the development of the e-learning curriculum
- work with a range of groups to improve the reach of the project, including to children and young people with learning difficulties and to deaf children and young people
- support all sites to submit data to the central portal, and continue to improve data quality and volume, with analysis of data fed back to sites
- undertake a full curriculum review.

7.6 Project governance

The CYP IAPT project is led by the Children, Families and Health Inequalities Division within DH (with input and support from the Mental Health Division), reporting to the IAPT Programme Board. Other government departments that have supported the project include the Department for Education, with representation on the Expert Reference Group (ERG) and the Service Development Task and Finish Group; the Department for Work and Pensions; and the Government Equalities Office.

The project is supported by an ERG, the members of which represent a range of interests, to advise on the delivery of the project. The ERG has established a series of task and finish groups, in which the operational work is carried out.

In addition, there are further wider, independent groups to act as 'critical friends', including:

- the British Psychological Society and Royal College of Psychiatrists, which jointly host an independent group of professional organisations, including voluntary sector organisations, whose remit is child and adolescent mental health
- a group of children and young people working at a national level, building on the participation of children and young people at a local level in project sites. In 2012/13, the project aims to commission an organisation to support consultation with parents.

The day-to-day planning and co-ordination is through a small project group made up of the National Clinical Advisor for CYP IAPT, the Department of Health CAMHS professional lead, the senior responsible officer (SRO), the CAMHS policy lead and policy manager, a project lead and an extended scope project manager, assisted by a project support officer. The project has a dedicated National Informatics Advisor, and as of 2012, a National Advisor for Counselling. The project has received support from colleagues working in adult IAPT, including the project team (in particular the informatics manager) and the IAPT national advisers.

The chairs of the task and finish groups and the CAMHS professional lead also meet regularly with the SRO.

8.0 Resources

8.1 Overall resources invested and impact

As part of the 2007 speding review, the IAPT programme received its first main stream funding in 2008/09, when £33 million was allocated. Further allocations of £103 million in 2009/10 and £173 million in 2010/11 were made.

The final £173 million was transferred to PCT baseline budgets, and further cumulative allocation of over £400 million was made to the programme as part of the 2010 Spending Review.

An estimated distribution of the additional funds is set out in Table 2. It should be noted that actual spend in each year is determined at local level and may therefore vary between years.

Table 2: Financial resources allocated to IAPT, 2011/12–2014/15

Policy	2011/12	2012/13	2013/14	2014/15
	£m	£m	£m	£m
Completing roll-out of IAPT, included in PCT baselines/ MPET allocation	43	88	133	133
Talking therapies for children and young people, held centrally	8	20	14	14
Piloting talking therapies for those with LTC/MUS, held centrally	0	2	2	0
Total	**51**	**110**	**149**	**147**

A core assumption of the economic modelling undertaken to support the IAPT business case is that there would be some displacement of pre-IAPT services, as:

- not all IAPT services are for new patients, i.e. patients who would not have been treated in pre-IAPT services previously
- GPs refer patients to an IAPT service where previously they would have referred those patients for a pre-IAPT talking therapies service
- there are instances of self-referral to IAPT talking therapies services, where previously those patients would have gone to their GP and sought pre-IAPT services through more traditional routes.

Little was known about the extent to which the expansion of IAPT services might represent an entirely new service created at the expense of displacing pre-IAPT service provision. IAPT services were initially expected to be additional to psychological therapies services that existed already. However, experience has shown that some local NHS services have taken the opportunity to review and adjust their psychological therapy provision because of the establishment of new IAPT service. There are also instances of existing services and therapists becoming IAPT accredited.

On balance, and based on expert opinion, it is assumed that 14% of the new IAPT services have either displaced pre-IAPT talking therapies services or have led to existing services and therapists becoming IAPT accredited. The remaining 86% of services are assumed to be completely new, offering services to patients who, in the absence of the expansion of IAPT services, would not be treated otherwise. The programme therefore aimed to secure a substantial net increase in local capacity of psychological therapy practitioners, rather than a re-badging of those already in the system.

8.2 Growth in IAPT investment

Investment patterns indicated by submissions to the national mapping exercises since 2004/05 are shown in Table 3.

Table 3: Psychological therapy services spend, 2004/05–2011/12

	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	20010/11	2011/12
	£m	£m	£m	£m	£m	£m	£m	£m
IAPT	0	0	0	0	0	119,719	168,849	214,240
Non-IAPT	144,378	142,047	146,116	161,378	184,755	172,589	186,972	174,740
Total	144,378	142,047	146,116	161,378	184,755	292,308	355,821	388,980
Percentage of adult mental health spend (%)	3.2	3.0	4.0	4.0	4.0	4.9	5.4	6.6

Although the consistency of data submissions both between sites and between years is irregular, the above data appears to be reassuring. Non-IAPT spend fell in 2009/10 but recovered the following year. Overall investment in non-IAPT psychological therapy services has consistently grown. With the addition of IAPT, there has been a substantial increase in the NHS's total investment in psychological therapies. When expressed as a percentage of the total NHS adult mental health spend, spend on talking therapies has risen from 3.2% to 6.6%.

Furthermore, a step change in investment is apparent in 2011/12. For the first time, IAPT spend was greater than non-IAPT spend. In addition, the overall proportion spent on talking therapies increased by over 1%, which represents the greatest single proportionate increase since the national mapping exercise began.

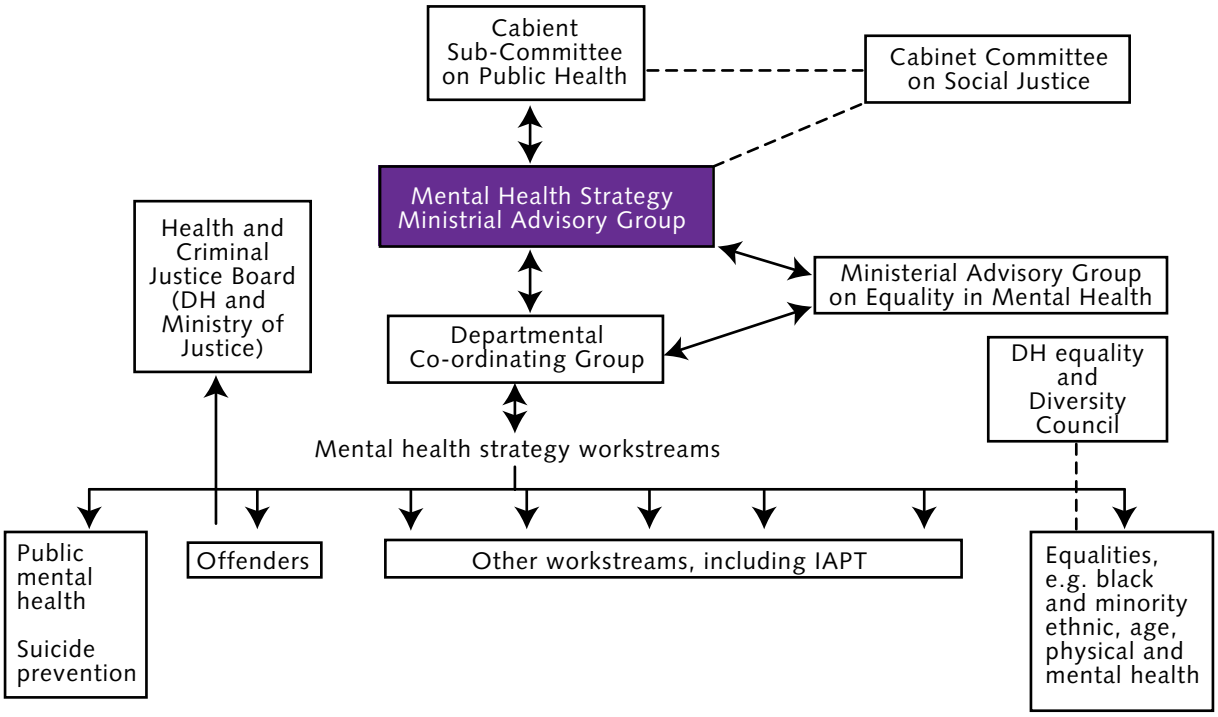
At present, 150 of the 151 PCTs in England commission an IAPT service, with a total of 240 services around the country.

9.0 Programme governance

9.1 National Mental Health Implementation Framework governance

The IAPT programme is a key workstream in the implementation of the national mental health strategy, *No health without mental health.* The programme governance arrangements sit within the context of the overall governance for implementation of the wider strategy, as indicated in Figure 5.

Figure 5: Mental Health Strategy Ministerial Advisory Group governance arrangements



9.2 IAPT governance structure

The IAPT programme is governed by its inter-agency Programme Board involving a broad range of stakeholders across statutory and non statutory organisations and other interest groups. This board oversees the activities of the programme and ensures alignment with the wider corporate agenda within the directorate, other parts of DH and government.

An executive and more operational role is held by the Programme Management Group (for adult IAPT services). Responsibility for the CYP IAPT project is assumed by the ERG.

Charlotte' experience

IAPT service user

Having CBT has turned my life around. I have changed the way I think and now view life with a completely different perspective. I used to judge myself and other people and viewed the world as a bad place. I now see the special things in life and am enjoying experiencing new things and meeting new people. My life is enriched!

10.0 Conclusions

England is partway through implementation of a large-scale programme to greatly increase the availability of evidence-based psychological therapies for depression and anxiety disorders across the life course.

The phased national roll-out of the core IAPT programme for adults is proceeding well and there have been significant improvements in:

- the number of people accessing psychological therapy services who would not previously have had this option
- recovery rates, which are now approaching those expected from the randomised controlled trials that generated the initial NICE recommendations
- session-by-session outcomes monitoring, with unprecedentedly high levels of pre- and post-treatment data completeness for key outcomes measures
- training of the new workforce closely aligned to the skills and competencies required for the specific treatments recommended by NICE
- employment attainment, employment retention and reductions in welfare benefit payments.

Lessons from the early stages of the programme are being used to provide guidance for less well-performing services. In the meantime, the extremely high levels of data completeness achieved by the IAPT programme has brought greater transparency to mental health services and helped clinicians and commissioners to identify both areas of excellence and areas that require further attention. Consideration will be given in the near future to the potential integration of the current IAPT and pre-existing mental health minimum datasets.

An ambitious work programme for 2012/13 is being pursued, building on progress to date and aiming to further improve the scale and scope of IAPT services and transform local mental health services. The programme is focusing on ensuring access to services for children and young people, older people, those from population groups with lower access than expected, and those with LTC, MUS and SMI. Additionally, the programme will be working closely with the emerging CCGs and health and wellbeing boards to achieve effective transition and ensure that IAPT is embedded in all commissioned mental health services.

The Health and Social Care Act has placed emphasis on people, communities and front-line staff in designing and delivering mental health services to meet local needs. *No health without mental health*, the cross-government mental health outcomes strategy, has

committed £400 million over the four years to 2014/15 to improve access to psychological therapies, ensuring that they are available and accessible to all who could benefit from them.

The Mental Health Implementation Framework and the Mandate to the NHS Commissioning Board[31] have committed to embedding equal priority for both mental and physical health needs in NHS-commissioned services. If we are to achieve our aim of achieving good mental health for all, we need to build resilience, promote mental health and wellbeing and challenge health inequalities. IAPT is fundamental to the implementation and success of these government initiatives.

Further information about the programme is available on the IAPT website at www.iapt.nhs.uk. Information about current services across the country can be accessed in the service directory pages on the NHS Choices website.[32]

31 https://www.wp.dh.gov.uk/publications/files/2012/11/mandate.pdf

32 www.nhs.uk/ServiceDirectories/Pages/ServiceSearchAdditional.aspx?ServiceType=TherapyAndCounsellingServices

11.0 List of abbreviations

Acronym	Full term
CAMHS	Children and Adolescent Mental Health Services
CBT	Cognitive behavioural therapy
CCG	Clinical commissioning groups
CYP	Children and young people
DH	Department of Health
ERG	Expert Reference Group
HEI	Higher education institution
IAPT	Improving Access to Psychological Therapies
KPI	Key performance indicator
LTC	Long-term condition
MPET	Multi-professional education and training
MUS	Medically unexplained symptoms
NICE	National Institute for Health and Clinical Excellence
O&I	Outcomes and informatics
NHS	National Health Service
PbR	Payment by results
PCT	Primary care trust
PD	Personality disorder
PWP	Psychological wellbeing practitioner
SHA	Strategic health authority
SMI	Severe mental illness
SRO	Senior responsible officer

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