

# **An evaluation of a new service model: Improving Access to Psychological Therapies demonstration sites 2006-2009**

## ***Executive Summary***

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# Executive summary

## ***Aim***

To conduct a multi-faceted, 'whole system' evaluation of two services demonstrating a new model Improving Access to Psychotherapy Services (IAPT) for people with common mental health problems.

## ***Research questions***

- The descriptive question: What form do the services take, how are they organised, whom do they see, what is the patient pathway and how many people are seen?
- The patient experience question: What is the experience of patients using the system and how satisfied are they with it? What lessons can be learned from their experience to improve services?
- The organisational question: What are the workforce implications of establishing an IAPT service, and what lessons on implementation and feasibility can be learned from the demonstration sites?
- The efficacy question: What improvements in mental health and functioning seem to follow from the implementation of an IAPT service? How do these improvements compare to those achieved historically, to those reported in randomised trials and other investigations, and to those achieved in comparable NHS mental health services?
- The effectiveness question: Do the new services perform any better than existing services in matched locations for the same client group? If so, is the improvement cost effective (or conversely, can the services achieve comparable outcomes at lower unit cost?)

## ***Methods***

A range of quantitative and qualitative methods was used to address these evaluation questions:

To investigate *service delivery and organisation*, extensive documentary evidence from each service was collected together with data on referrals, assessment, treatment and clinical outcome, routinely collected by the two services from June 2006 to April 2009. These data were anonymised and descriptive statistics were used to provide information on service inputs, processes, outputs and outcomes.

To investigate *organisational processes in implementing the innovation*, we conducted an organisational case study, interviewing a purposive sample of 57 stakeholders within the IAPT sites and analysing transcripts thematically.

To investigate the *patient experiences of, and care pathways through, IAPT services* we used a qualitative exploration of key themes using in-depth interviews with 77 patients and analyses informed by the Framework method.

To investigate *service effectiveness*, outcome data were analysed statistically and compared with benchmarks calculated from archived primary care mental health services datasets and from randomised controlled clinical trials in depression and anxiety disorders.

To investigate *cost effectiveness*, a postal questionnaire study of 504 people examined service costs and outcomes for primary care patients eligible for IAPT within the demonstration sites, compared with similar patients in comparison sites, matched on a range of socio-demographic factors.

To investigate *patients' access to IAPT and the impact of IAPT on use of hospital services, sickness certification and psychotropic medication*, we used an innovative health informatics method linking de-identified data from General Practice IT systems, secondary service use datasets and the IAPT datasets.

## **Main findings**

The two services differed widely in their local context and the model of service they aspired to provide. Both demonstration services succeeded in improving access to psychological therapies. One site achieved a high volume capacity through providing collaborative care: primarily CBT-informed guided self help rather than formal cognitive behaviour therapy; the other evolved a model of delivery which balanced guided self help with a higher volume CBT service.

Other successful aspects of the demonstration services included the use of non-traditional access pathways such as self-referral and referrals through the 'pathways to work' programme. Also demonstrated were the use of community outreach and intensive efforts to engage hard-to-reach populations such as people from black and minority ethnic groups.

Difficult challenges for the services included the extraordinary time pressures to establish complex services and difficulties establishing genuine partnership working between primary and secondary care, with non-NHS organisations and with service users.

Both services were characterised by short waiting times for first contact, an assessment process that 'signposted' people to other services and referrals that included a wide range of severity of problem. The services were used by unemployed people and people on benefits, who tended to have more severe difficulties.

The organisational process of implementation provided valuable insights into helpful and hindering factors in implementation. Ways to improve partnership working were outlined, and the defining characteristics of the

IAPT innovation emerged clearly in terms of addressing mental health inequalities, breaking down barriers and creating a service that supported individuals in remaining active in society and in their community. Moving away from traditional clinical delivery methods was cited as a key way of avoiding some of the stigma attached to mental health issues, overcoming shortfalls in support for those in employment who are finding it difficult to cope and in providing access to those in previously hard to reach communities i.e. those from black and ethnic minority communities and non English speakers. Achieving a genuinely seamless pathway by good collaboration between primary and secondary services was an enduring difficulty and requires continuing attention.

Discussing with patients their experience of the IAPT service showed the importance of the first contact with their GP and with the IAPT service in helping to identify the problem, provide hope and a way forward. This was particularly helpful when people had a sense of control and choice and were seen quickly. Self-referral was often associated with feeling greater self-confidence and hope. However, some patients experienced little or no choice in either referral or treatment options and information that could have helped in decision-making was often not available.

The best experience for patients in terms of guided self-help interventions was characterised by good communication and working with responsive, flexible, and respectful psychological wellbeing practitioners in a structured format tailored to their needs. Negative experience was reported when the practitioner was seen as impersonal, self-help booklets were not pitched at the right level and although there were patients who liked the freedom of telephone contacts and the computerized packages, many found them problematic. Careful introduction, some one-to-one sessions and real support helped improve the value of telephone/computer working.

Cognitive behaviour therapy was generally valued, but was often thought to be too short. A lack of continuity (due to staff turnover) or follow-up was problematic for patients. Service users' testimony underlined the importance of genuine choice and consent rather than assuming consent from passive acquiescence in this model of service delivery.

In terms of outcomes, in terms of the least stringent criterion, both services fell only marginally short of the 50% recovery rate set by the Department of Health as the target for those receiving a minimum treatment of two or more contacts. The target rate of recovery was exceeded when considering those patients who completed their individually agreed treatment plans.

Comparisons with previous primary care therapy service outcomes suggest that the new services delivered a service of equivalent effectiveness despite being newly-established and delivered by relatively inexperienced practitioners; this is a considerable achievement. Comparison with results reported in research trials showed therapy effects were slightly less favourable, a finding consistent with previous research.

The postal questionnaire survey generally found patients' well being and mental health had improved over four and eight month intervals, but this

was matched by improvements in the comparison sites, giving very little difference in outcome between the IAPT demonstration sites and the comparators, although poor response rates to the questionnaire throws doubt on the robustness of this finding. Resource use did not change significantly for most of the mental health services that were reported across the IAPT sites and their matched comparator sites, but GP consultations and other health service use in Doncaster reduced more than in the comparison sites.

This study compared the costs and outcomes of patients recruited to the two demonstration sites of Doncaster and Newham with those achieved at comparator sites in Wakefield and Barnsley and City and Hackney respectively. Service costs were found to be £263 (95% CI: -£258 to £779) higher in Doncaster compared to Wakefield and Barnsley and £561 (95% CI: -£333 to £1,451) higher in Newham compared to City and Hackney over 8 months for IAPT. These additional costs of IAPT generated 0.007 (95% CI: -0.006 to 0.021) additional Quality Adjusted Life Years (QALYS) in Doncaster but was associated with QALY losses in Newham, -0.002 (95% CI: -0.035 to 0.031), compared to their respective matched sites. This resulted in an incremental cost effectiveness ratio (ICER) of £37,571 per QALY when Doncaster was compared to Wakefield and Barnsley but the probability that IAPT was cost effective was below 40%. However, using QALY estimates based on EQ-5D predictions brought down the ICER to £20,230 but with a probability that IAPT was cost effective of just over 40%. Lost employment costs were higher for Doncaster compared to Wakefield & Barnsley, £279 (95% CI: -£65 to £624) but lower for Newham compared to City & Hackney, -£212 (95% CI: -£522 to £98) although these differences fell to £67 in Doncaster compared to Wakefield and Barnsley when outliers were removed. These results indicate that the Doncaster IAPT demonstration site provided a service that was probably cost-effective within the usual NICE threshold range of £20,000-30,000, but there was considerable uncertainty surrounding the costs and outcome differences and it was somewhat undermined by the low response rate to the patient questionnaire (though comparisons with the IAPT suggest this may have resulted in an underestimate of the cost effectiveness of this service). It is not possible to comment on the cost effectiveness of the Newham service since the numbers were too low and the comparator site adopted an IAPT service during the study.

The general practice study findings suggest that IAPT referral is being appropriately targeted on people with a greater severity of problem, sickness certification and use of medication, and although it is not reducing antidepressant prescribing overall, it seems to be reducing sickness certification and may lead to a reduction in the use of Accident and Emergency attendances. These potential benefits at the practice level are diluted by the small proportion (6%) of people with common mental health problems who are referred.

## ***Conclusions***

Results from the demonstration sites show that both services were successfully established and offered good access to collaborative care for people with common mental health problems. Results met Department of Health expectations and were equivalent to psychological therapies delivered by other primary care practitioners, with evidence of reduction in sickness certification and possibly in the use of some secondary health services. Return to work was demonstrated but not specifically attributable to the IAPT intervention. We were able to estimate incremental cost effectiveness for the Doncaster service, which gave a probable ratio within the range of the NICE threshold.

## Addendum

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton.

Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact [sdo@southampton.ac.uk](mailto:sdo@southampton.ac.uk).