

IAPT South West Evaluation
Interim Report – Executive Summary

The South West
Improving Access to Psychological Therapies (IAPT)
Evaluation Study

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Research conducted by:

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1.0 EXECUTIVE SUMMARY

1.1 Introduction

Mental health problems account for over a third of all illness in Britain and 40% of all disabilities, according to government figures. At any time one in six working adults is experiencing depression or anxiety, or both. There is growing recognition of the links between mental ill-health and social exclusion, including worklessness.

Despite the prevalence of mental health problems and the consequences of mental illness for individuals, families, and society more generally, access to therapeutic treatment within the NHS has been highly variable. In 2008 the government implemented IAPT (Improving Access to Psychological Therapies), a national stepped care programme, with training of CBT (Cognitive Behavioural Therapy) practitioners at its heart. The aims were to improve: access (the number of people receiving a service and the different groups accessing the service); effectiveness (improvements in people's mental health through use of evidence informed treatments); and efficiency (organising resources in a way that maximises health gain to society). Services commissioned were required to use the national IAPT dataset, have stepped care and a team structure with qualified supervisors; however the exact configuration was left to local commissioners and providers. In the South West a decision was made to share the initial investment across all Primary Care Trusts (PCTs). The PCT services went live in three waves: October 2008, April 2009 and October 2009.

This research evaluation, commissioned by the South West Strategic Health Authority (SHA), aims to contribute to the improvement of IAPT services locally, and produce generalisable results. It is being carried out in a collaborative way, through a strong partnership between the Peninsula Medical School and the South West Development Centre. Patients, commissioners and providers have been involved at all stages. It aims to evaluate the approach taken to developing the Improving Access to Psychological Therapies programme by the SHA and the individual PCTs.

Research questions included:

- a) What are the different models PCTs adopt, including locations, pathways, sizes, key roles as well as throughput and access?
- b) How do PCT and local IAPT services differ in their ability to achieve successful implementation and outcomes? Why?
- c) Which models are most effective in achieving access and treatment targets, and mental health outcomes? Why?

1.2 Method

1. Developing a taxonomy of 'design factors' for the IAPT services and using a questionnaire to assess the 14 PCTs

- Carrying out in depth case studies of four diverse services including:
- Description of services in each site
- Cross site analysis of patient pathways based on interviews with practitioners (21) and patients (14)

- Questionnaire survey of IAPT practitioners, General Practitioners (GPs) and non IAPT practitioners (n=329)
2. Analysis of the IAPT patient data set including:
 - PCT by PCT analysis of key measures of access, process and outcomes, and Quality and Learning Measures (QuALMs).
 - Cross regional analysis of IAPT data set to examine the predictors of waiting time and outcome
 3. Synthesis of results from different sub studies examining the reasons for differences in key access outcomes.

1.3 Results

The results, relating to patient level data from October 2008 to September 2010, demonstrate a wholesale change to the way psychological therapies are delivered across the South West. Further achievements have occurred in the interim. There is, however, variation both in the way IAPT services are operating and their achievements. While within PCTs there is little variation in mental health outcome, rates of access varied seven fold, from 3-21 per thousand per annum; access rates are highly correlated with referrals, mainly following general practitioner contact. Two wave three services, Plymouth and Wiltshire, achieved relatively high rates after one year. Perhaps more remarkably, variations in waiting time, which are also significant, do not correlate, as might be expected, with access rates. Two PCTs, sharing one service provider, achieved the highest access rates with low waiting times.

This is illustrated in Figure 1: Scatter plot of mean waiting time (days) against access (episodes of care per 1000 pop. per year) showing clusters of PCTs in final time period (April-Sept, 2010)., an innovative means of displaying key outcomes for services. These are adjusted for population but not for any variation in funding and resources which may have occurred despite central funding allocations being population based.

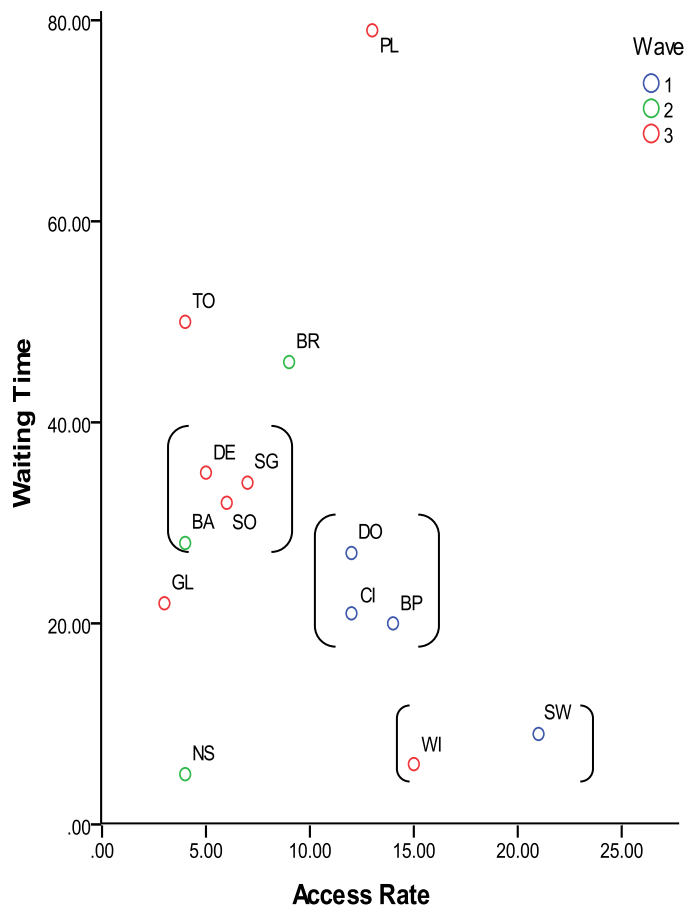


Figure 1: Scatter plot of mean waiting time (days) against access (episodes of care per 1000 pop. per year) showing clusters of PCTs¹ in final time period (April-Sept, 2010).

A significant amount of the heterogeneity is likely to be due to the variance in start-up times - the data was collected after some services had been operating for a year and others for up to two years. Some services had been operating in a similar form to that required for IAPT for longer than the two years and were therefore likely to be at considerable advantage. Furthermore, some providers, when starting up IAPT services, had to take on large waiting lists from decommissioned services which left them at a considerable disadvantage. One of the aims of the study is to tease out those design factors which are responsible for optimum performance of the IAPT services.

1.3.1 Service Design Factors

The Design Factor Questionnaire was sent to each of the services in the 14 PCTs. It is based on a taxonomy of service factors across the patient pathway and shows significant variation in some areas, and homogeneity for others. For example, most services are homogenous in terms of providing open access, allowing patient self-referrals, having a

¹ GL = Gloucestershire, PL = Plymouth, DE = Devon, CI = Cornwall & Isles of Scilly, BR = Bristol, DO = Dorset, BA = B&NES (Bath & North East Somerset), NS = North Somerset, BP = Bournemouth & Poole, SO = Somerset, TO = Torbay, SW = Swindon, SG = South Gloucestershire, WI = Wiltshire

website and practitioners based in general practices. Most have an “opt in” system, but this operates in a number of ways.

The survey revealed a number of significant differences within aspects of access related service design, including, significant variation in the availability of appointments out of hours and at weekends; highly significant variation in the services offered for those hard of hearing and for those with learning disabilities. Services had selected particular groups to provide outreach to, but none provided outreach services consistently across the range of vulnerable groups. Exclusion criteria were apparent in most services, although only one excluded those who were not severe enough. Two services had a very different approach, including patients well beyond the normal IAPT remit, welcoming all residents living in their catchment area including those with stable psychosis and drug and alcohol problems who also had anxiety or depression.

There were a range of arrangements for screening and making appointments and making contact with patients which were complex and were not fully defined within the questionnaire. Some services made considerable use of telephoning in order to make contact with patients, some to carry out initial assessments and others to carry out therapy (or assessment and therapy). The variety of services provided also varied significantly. While all services, being IAPT services, had low and high intensity workers providing Cognitive Behavioural Therapy (CBT), the range of low intensity therapies varied, with many services running small groups and larger psycho-educational courses. Formal group therapy was only provided at step three. Counselling was not provided universally by services and other specialised services, such as Movement and Desensitisation Reprocessing (EMDR) and Interpersonal Psychotherapy (IPT) were even more variable.

Stepping up to high intensity therapy (HI) was usual for those who did not respond to low intensity therapy (LI), although many services directed severe patients or those with specific conditions straight to high intensity therapy. It was notable that only one service reported routinely following up patients at the end of therapy, regardless of whether improvements have been shown in outcomes. Liaison with other services was variable and while all services aimed to communicate with GPs their methods of achieving this were heterogeneous. Few were providing regular education, but all made efforts to communicate with individual practices. Only a few had dedicated link workers. Links with secondary care were also highly variable with some services having routine meetings, checking databases and one service taking a significant proportion of referrals from secondary care.

1.3.2 Case Studies

The case studies in Bristol, Cornwall, Devon and Swindon describe the design of the four different services. These services were chosen because they represented both urban and rural, tendered and non-tendered services and included wave 1, 2 and 3 sites. An NHS primary care mental health service had been in existence in Swindon prior to the IAPT service, whilst Cornwall and Bristol are new non NHS services, although the Cornwall service had been set up in the year before IAPT commissioning. The Devon service is a new NHS service which replaced previous smaller NHS services.

Case studies involved interviews with practitioners and managers (21) and patients (14); these and further analyses are on-going. Questionnaires were sent to 329 IAPT practitioners, GPs and secondary mental health workers.

The initial analysis case studies detail variation in access, referral, triage, assessment, pathways, relationships with other services, and gaps in provision. Promotion of the services varied, with wave 1 sites Cornwall and Swindon having active campaigns to recruit people to their service and offering both GP and self-referral. Bristol had recently started to offer self-referral, whilst Devon had made the decision not to promote their service or offer self-referral until their inherited waiting lists were under control.

Access arrangements varied considerably with most services processing a referral (self or GP) before arranging an appointment. In Swindon, however, patients could book directly into step 2 individual therapy or a variety of psycho-educational courses with no prior central processing of referrals. Booking could be made through the website, by telephone or through GP receptionists. This system of 'opting in' through 'multiple points of access' was very different from that operated by many other services where 'opting in', designed to ensure that only those really wanting the service are assessed, introduces a further transactional hurdle for patients to overcome. Furthermore formal assessments are not carried out for those booking in to step 2 sessions, with the minimum data set collected at the first treatment session instead.

The other major difference between the case study services was that in Bristol, Devon and Cornwall patients were discharged after an episode of care, whilst in Swindon patients are not discharged and are encouraged to return direct to the service if they want to.

Lack of appropriate accommodation was considered to be a problem in Devon and Bristol, but not in Swindon. Cornwall staff reported that as not all GP surgeries could accommodate their workers, they had access to additional accommodation in seven localities to resolve this issue. While there was evidence of more integration with primary care in Swindon, none of the services are operating a true collaborative care model.

The staff interviews revealed that particular patient groups fell into a gap between IAPT and secondary care services. These included those with less severe mental health difficulties, other than anxiety and depression, and those with long term mental health conditions, too complex for IAPT but not severe enough to be treated by secondary care services. One GP suggested that this was brought about by the different criteria for accepting patients in primary and secondary care. The IAPT services are designed to provide short term care for those with anxiety and depression whilst secondary care mental health teams provide services for those with severe and enduring difficulties. Hence those with longer term less severe illness such as personality difficulties or recurrent depression may not receive care from either service. This was felt to be less of an issue for Swindon who have longstanding links with secondary care and have promoted their service as providing help for anxiety and depression to all for as long as they need it. In Devon the communication between secondary care and IAPT services was reported to be good as they have the same provider. Cornwall and Bristol service had been addressing this issue by holding meetings between service representatives and secondary care to agree policies for complex referrals.

The analysis of the patient interviews examined how variation in the delivery of IAPT services affects patient experience. Patients talked of the skills that they had learnt and how they took great comfort from both therapist contact and competence. They also stressed the importance of patient choice with some preferring group work/ psycho-educational courses because of feelings of solidarity generated through meeting others “in a similar boat”. In contrast, others didn’t want to ‘share issues’ with people they didn’t know but weren’t always offered one to one therapy. There were concerns in both staff and patient interviews over waiting lists with even a three week wait being seen by one patient as “pretty torturous”.

Practitioners completing the survey were all too aware of the problems of patients waiting and of how expectations are not always met. Waiting time was reported to be significantly more acceptable in Swindon than in Cornwall, though the waiting time in Cornwall was significantly more acceptable than in both Devon and Bristol.

For the majority of questions asked about the quality of the services and relationships between the service and other services, the Swindon service was rated highest followed by Cornwall and then the others. The effect sizes were small, but the differences were statistically significant; however it should be noted again that Devon and Bristol were not first wave services. Overall, treatment was rated as effective in all of the services, but services for those with drug and alcohol problems, offenders and those with personality disorders were considered poor compared to services for those with physical conditions, parents, and those who are housebound.

In the survey IAPT practitioners typically rated their service more highly than GPs or secondary care workers. This may have reflected optimistic bias in their abilities, or have represented greater knowledge in the effectiveness of the treatment that they provide.

1.3.3 Cross regional analysis and Quality and Learning Measures (QuALMs)

Data sets from each of 14 services were held by the Peninsula Clinical Trials Unit (CTU). These were used for cross regional analysis and PCT by PCT comparison of data.

A cross regional multi-level linear regression analysis using data from twelve services was carried out to examine the predictors of mental health outcome for those with more than one clinical contact². In this initial analysis of the data greater subsequent improvements in depression and anxiety scores were associated with increasing age, increasing socio-economic status (represented by postcode) and higher initial anxiety and depression. Increases in the number of sessions and amount face to face therapy time, as well as duration of therapy also each make a small contribution to improvements in depression and anxiety.

Separate analyses were carried out to compare therapy types³. Low and high intensity therapies did not differ in their improvement of depression and anxiety. Counselling had a

² The proportion varied from 29-74% of individuals making contact with the service.

³ Outcome change is calculated as the difference between a patients first and last clinical contacts of an episode of care. As some of the services with a high percentage of groups do not discharge their patients, their mean outcome change may be artificially reduced (the ‘last’ clinical contact could potentially be the first clinical contact of a ‘new’ episode of care following a relapse). Furthermore the

similar effect to individual CBT, and both were associated with statistically greater improvements in anxiety and depression scores than group-based interventions (approximately 0.5 on both General Anxiety Disorder (GAD-7) and Patient Health Questionnaire (PHQ-9) scales).

QuALMS (Quality and Learning Measures) were developed based on the availability of data within the national IAPT dataset, through an understanding of likely determinants of outcomes and through discussions with the services themselves. While there are significant cautions to be applied to the analysis of data merged from fourteen services using two IT systems, the use of the national IAPT dataset does allow comparisons to be made.

While access rates per year per 1000 population are correlated with referral rates, drop-out rates do vary significantly. There is also significant variation in processes of care, particularly in the types of therapy received at first contact (shown in Table 1). The first part of Table 1 shows service design measures for the last six month period of data collected⁴. The second part of Table 1 shows baseline measures of depression and anxiety and the change in those outcomes for data from the entire period of data collected⁵.

The results reflect and validate the design factor questionnaire results with most services carrying out formal assessments as advocated by IAPT guidance. The percentage of patients receiving group based psycho-education at their initial clinical contact varied from 0% (Bristol, Dorset, Bournemouth & Poole and South Gloucestershire) to around 40% (Swindon and Wiltshire).

There was some variation in the outcome improvement rates and a PCT-by-PCT comparison of outcome changes of depression and anxiety (PHQ-9 and GAD-7) was carried out using the two data sets described above². With Bournemouth & Poole as the reference, Bath and North East Somerset (B&NES) was found to have the greatest improvement in both depression and anxiety, with two services being significantly lower⁶. Swindon also had marginally lower rates of improvement for GAD-7. The average number of contacts per episode of care did not differ greatly between services (only B&NES had more than 4 contacts (n = 6), all other services had between 3 and 4 contacts per episode of care).

data sets included individuals half way through therapy. Two data sets were therefore produced, the first only including those with no contact in the six weeks before the end of the data set (completed treatment); and the second using an artificial cut off of 200 days (histograms of therapy time were examined for each service, which showed that therapy time tailed off at approximately 200 days). Analyses were rerun for the subset of patients who completed treatment within 200 days. The results from these analyses did not differ significantly from the previous analyses on the larger dataset as described above.

⁴ Services general improved over time, so the last six month period was chosen to represent provision in late 2010.

⁵ Due to the use of six week cut offs cut-offs (not currently in a waiting list or active in the last six weeks prior to the data download used for the database) used in these analyses, the last six month period has fewer complete records with fewer attended sessions. Outcome changes are artificially low within this period, and so analyses were conducted on the entirety of the data.

⁶ Somerset and Bristol were excluded from the analyses due to data quality issues. North Somerset had a low number of records suitable for analysis, so were not part of the final analyses.

Table 1: Key QuALMs indicators

Summary of key indicators	GL	PL	DE	CI	BR	DO	BA	NS	BP	SO	TO	SW	SG	WI
Referral Rate	9	18	9	29	16	19	8	16	19	12	13	19	13	13
Access Rate	3	13	5	12	9	12	4	4	14	6	4	21	7	15
% dropout	66	30	46	57	43	40	49	75	24	45	70	-	47	-
Mean N of contacts per episode of care	4	3	4	3	3	3	6	3	4	3	3	4	4	4
Waiting time	22	79	35	21	46	27	28	5	20	32	50	9	34	6
Most common initial contact	ASS	AAT LI	ASS	AAT LI	ASS	AAT LI	ASS	ASS	ASS	ASS	ASS	AAT GR	ASS	AAT GR
% attending group initially ⁷	8	14	21	4	0	0	11	3	0	1	30	44	0	41
Baseline PHQ-9 (m.,s.d.)	14.4 6.3	14.2 6.6	12.9 6.3	14.4 6.4	14.3 6.4	13.8 6.8	12.6 6.1	15.4 6.5	14.7 6.4	13.8 7.1	13.4 6.6	14.0 6.9	13.0 7.0	13.7 7.2
Baseline GAD-7 (m.,s.d.)	12.9 5.0	12.9 5.7	11.7 5.5	12.8 5.4	12.8 5.4	12.6 5.5	12.1 5.0	13.4 4.6	12.9 5.4	11.2 6.0	12.1 5.5	12.1 5.5	11.0 6.0	12.3 5.8
PHQ-9 change	6.0	4.6	4.3	5.1	3.9	5.5	6.3	4.6	5.4	2.9	4.7	4.7	3.5	4.7
GAD-7 change	5.2	4.3	3.8	4.5	2.0	4.9	6.0	4.4	4.6	2.9	4.6	3.9	2.8	4.0

ASS = Assessment; AAT = Assessment and Treatment; LI = Low Intensity treatment (CBT); GR = Group-based treatment/psycho-education; m.,s.d.= Mean, Standard deviation

1.4 Synthesis

The synthesis of results focused on examining and explaining how the design factors influenced the variation in outcomes described above and depicted in figure 1. The synthesis was carried out in stages: a) The outcomes were examined in detail and services clustered according to similarities in outcome; b) sub-studies were systematically examined first for any confirmatory and disconfirmatory evidence related to outcomes; and c) then examined for evidence to explain variation in terms of service design.

⁷ Percentage of patients receiving group therapy at initial clinical contact, as this impacts upon waiting time and numbers gaining access

When the relationship between access and waiting list was further examined, three different patterns emerged. A group of services appeared to cluster on the centre of what might have been considered the expected line (waiting time increasing with referral and access). These included Devon, B&NES, Somerset and South Gloucester (Cluster A). To the right on the scatter plot are a group of three services, Dorset, Bournemouth and Poole and Cornwall (Cluster B) with moderate high access rate and moderate waiting times. Further along this unexpected axis lies Wiltshire and Swindon with very low waiting time and moderate and high access rates respectively (Cluster C). It is noted that there are some services that do not fit into these 3 clusters. Plymouth for example, a new service with high levels of referrals and a large inherited waiting list, was unable to keep waiting times down in the first year; this was more consistent with our original predictions. Further examination of the characteristics of the services within clusters A (Devon, B&NES, Somerset and South Gloucester) and B (Dorset, Bournemouth and Poole and Cornwall), showed heterogeneity with respect to service design, data from QuALMs and qualitative data. Cluster C contained Swindon and Wiltshire, run by the same service, so apart from IAPT service start date these PCTs had the same characteristics. Therefore further explanations of differences in service and patient level factors with respect to service level factors and individual (mental health) outcomes focused on factors explaining differences between Swindon/Wiltshire and all other services (clustered services and the outlying services (Plymouth, Torbay, Bristol, Gloucestershire and North Somerset)).

Results from the case studies revealed mainly confirmatory evidence: high levels of satisfaction with the Swindon service (and to a lesser extent Cornwall service) in most questions, and little concern within the interviews about waiting times and capacity. There was no evidence of reduced contact rates in this service, although a significant proportion of patients attended groups. Examination of mental health outcomes showed no significant differences when compared by cluster, however as described above, outcomes for Wiltshire and Swindon were marginally lower than the reference service.

In order to explain these results, the design factor questionnaire results were re-examined first. Typically wave 1 sites had higher access and lower wait times than wave 2 and 3 services, but some wave 3 services performed better than expected. Swindon and Wiltshire services both had a lower waiting list at the start of their service, a greater proportion of step 2 workers, and a lower number of trainee staff than the other services. Along with one other service they had a higher proportion of practitioners who had been working for the service for more than two years. Commissioning arrangements were not obviously associated with performance.

The results of the case studies further illustrated differences in service design for those services falling into different clusters. Swindon and Wiltshire use the LIFT (Least Intervention First Time) model more rigorously than other services; patients are typically offered a variety of step 2 interventions first before High Intensity CBT; only if step 2 treatments are not successful, or if patients have conditions like Post Traumatic Stress Disorder (PTSD) or Obsessive Compulsive Disorder (OCD) (where step 3 is recommended in National Institute for Health and Clinical Excellence (NICE) guidelines as the first treatment) would patients receive step 3 as a first intervention.

Swindon and Wiltshire patients accessing the wide range of step 2 treatments (group and individually based) do not have a formal assessment first. This is a different model of care to

that used in the other 3 case study sites where patients have an assessment before accessing step 2 treatment (as recommended by IAPT national guidance). Furthermore patients can book treatment directly at their GP surgery, by telephone or via a website – ‘multiple points of access’.

Lack of accommodation had been reported as a problem in Devon and Bristol and a problem that has been resolved at additional cost by the Cornwall service. No accommodation problems were reported in Swindon, but the Swindon service insists that GPs surgeries agree for any Swindon patient to be seen at their surgery, not just their own patients. This means that appointment slots can be used more efficiently.

Outcomes

Significantly better outcomes were demonstrated in B&NES than other services. In relation to design factors, B&NES employs a greater proportion of high intensity practitioners delivering CBT based interventions than some other services. However, they are not unique in this approach. B&NES however, does report only a small number of trainee staff in the design factor questionnaire results, so it is possible that their more experienced staff are helping to deliver better outcomes. Further, they were the only service to report routinely following up patients, a practice which has an evidence base to support it and in theory should pick up those who have not recovered and offer further interventions.

1.5 Summary

In summary, significant achievements have occurred across the southwest, and the Swindon and Wiltshire service has been able to deliver greatest access and shortest waiting times, without markedly reducing mental health outcomes. Services which had started earlier and did not inherit waiting lists appear more likely to achieve high access without high waiting times. Nevertheless we suggest that not all the differences in performance can be put down to these factors and it is likely that service design factors are responsible for a significant proportion of the variation in performance.

The following service design factors were associated with greater access and lower waiting times: greater promotion of services including a website with a central advertised telephone number; good integration with GP practices; a greater proportion and a greater range of group based interventions to choose from; a greater proportion of step 2 workers; not having assessments prior to therapy; and multiple access methods (telephone, GP receptionist, and internet-based booking) including direct booking in GP surgeries. Inevitably a number of other factors which we had not measured directly, such as leadership and morale are also likely to have an impact on performance.

With respect to mental health outcomes the greatest improvements were associated with more severe baseline scores on measures of anxiety and depression, lower deprivation, higher age, greater duration of treatment and to a lesser degree type of therapy. There were some small differences between services. It is possible that the B&NES service was able to deliver significantly better outcomes due to the combination of assertive follow up and high

proportion of fully trained staff; this will be investigated in the next round of the project if the association persists.

These associations do not prove causation, but the very large differences in access rates require an explanation and further investigation. Commissioners and patients in other services may want to consider whether their model represents the most efficient use of investment in psychological services. The project will look at the replicability of findings; investigate the experience of those not taken on by services and take a health economics perspective in the final year.