Transcript of roundtable with practitioners for the Health and Social Care Committee Mental Health Expert Panel on Tuesday 12th October 2021.

Group 3: Adult Common Mental Health

Alex Lloyd: Thank you everyone. We'll start by looking at what we will be discussing today. The commitment that we are going to discussing today is broadly within the remit of the IAPT treatment but looking specifically at the delivery and integration of long-term condition services within the IAPT provision. Obviously, you'll have broad reaching expertise around this but if I could ask you to specifically focus on that commitment as that would really help our evaluation. The first question that I would like to ask is: in your experience is the Government meeting its commitment that all areas should commission IAPT long-term condition services, including the co-location of therapists in primary care.

Participant A: I'll go first, and I think this is going to be quick. I work in a learning disability service and we will, as a default, refer any service users with an acute mental health need to our mainstream mental health services. Our service exists to support people to access mainstream services where possible- usually with some reasonable adjustments- and if those mainstream services can't work with our service users then we provide the work ourselves. There is a long-standing difficulty in referring people with learning disabilities to mainstream services in that they're overburdened, and often just the mention of a learning disability is enough for them to refer them back to us to see if we'll do the work. Learning disabilities and autism are lifelong conditions, we don't get referrals for those conditions, we get referrals for people with various difficulties secondary to them. In our county there are four providers of IAPT, and none of them are currently taking referrals for long-term conditions. I contacted the manager for our Trust's IAPT services before this meeting, and they told me that this may change in the future but they're currently working in the contract with the CCGs. So, a bit shamefully, that's the state of play where I am for people with learning disabilities and autism if they have a long-term condition that is affecting their mental health. I think the LD service would pick them up, but we are all operating on episodes of care models, so it would be seeing them, finding a problem and then closing the care after that.

Participant B: Just on that point, IAPT for people with learning disabilities and autism the problem we're having is resistance by services about working with this group of people. Regardless of us advocating on their behalf for years and years there is just this real resistance, which is against legislation, equality legislation and DDA as well, but they just seem to be quite unbending. When you do engage with them as much as you can you're expecting reasonable adjustments to take place, but this doesn't always happen. It seems as though they want to complete the work within 6 or 8 sessions, whereas people with autism or learning disabilities might require longer periods of time and this seems to be a big barrier for us.

Alex Lloyd: Thank you. That's a really helpful contribution.

Participant C: I'd like to start with a question Alex. So the commitments around IAPT in the Five Year Forward View has, as you say, for all areas to provide an additional long-term condition service to their existing IAPT service, and for their existing IAPT service to expand to be able to meet 25% of the prevalence of depression and anxiety by 2023/24. And I think by 2020/21 the aim was to get to 1.6 million referrals into treatment as the access standard to maintain the waiting times expected, with 90% of people seen within 18 weeks and 75% seen within 4 weeks. So you haven't mentioned these other access standards that were in the Five Year Forward View and was there a reason for not discussion that and for focusing on the long-term conditions work?

Alex Lloyd: Yes, that's a really important question. When the expert panel set out to evaluate these commitments the specialists tried to whittle it down, because there are so many of those commitments, to those that they thought would be generalisable to be able to address those other very important commitments. I think that they were just looking for the benefits as well as the specifics of these particular commitments. But I take your point, it's something that will of course wrap into these discussions as well, so do feel free to draw on those other elements as well.

Participant D: I welcome the emphasis on long-term and severe conditions. Obviously, we've had, what is it now, about 15 years or more of IAPT emphasising commons mental health problems, particularly anxiety and depression. I have to say as somebody with a CBT background and training I'm pleased that there has been the extra investment in that kind of intervention, and that many people have had access. But the concern that I have is essentially about the stepped care model. My problem with it is that I'm aware of lots of people who've essentially been immunised against CBT because they think that they've had CBT, when actually they haven't. They've had a very watered-down version right at the very first level, of step, of the stepped care model. It hasn't worked for them and they've gone away thinking well I've tried CBT and it doesn't work for me. My view is that we need to move towards a more expert on the door model: somebody who has a great deal of experience to initially evaluation the nature of the person's problem and what kind of interaction would be appropriate. My understanding is that the stepped care model has been trialled in Accident and Emergency, and they very quickly realised that it doesn't work and that you have the most experienced person at the front door to make things happen. So that's my main concern. I would say in regard to the development of resilience huts, I know that they're primarily aimed at the NHS workforce, and I'm pleased that we're getting more of an expert on the door approach in that regard. As you know the resilience hubs are referring on, often to IAPT, but other mental health services as well and that is following a fairly detailed assessment. That's where I'm coming from.

Alex Lloyd: Thank you. That's really helpful and there is something that I'd like to pick up on, that maybe the wider group can also comment on. You said about needing the appropriate course of treatment in place very early on, and my understanding with the long-term condition provision for IAPT is that they would have therapists, or people that were qualified, to understand the long-term health condition alongside the mental health needs of the person. So, bearing that in mind, do you think this is an appropriate commitment, do you think it is a good way to go to enhance what IAPT is already meant to be doing?

Participant D: I think so yes. But we're at a very early stage with the long-term and severe problems with IAPT aren't we, so time will tell.

Alex Lloyd: Absolutely, yes. Participant E would you like to jump in?

Participant E: Yes. Sorry I missed the beginning, but if I understand correctly at the moment we're talking about IAPT, specifically around it's needs to provide for those with long term conditions.

Alex Lloyd: Yes, that's correct.

Participant E: So I want to echo everything that Participant D said. I think that's immensely sensible. I'm a psychiatrist and I work in a specialist muscular skeletal hospital, and one would think that working in such a specialist field I would have less to do with the community provision for people with mental health conditions, but actually it's absolutely essential and a lot of my patients seem to fall between the gap. I lead the spinal injuries centre here, but about 85% of my outpatient work here is for people with chronic pain conditions. We have a chronic pain service, which primarily deals with inpatient work, a pain management programme, and they're not commissioned really to do any

outpatient work- but they still do as much as they can- and we therefore rely on local IAPT services. And at times it is a Godsend because I remember the times when I was in training, and IAPT was only just starting up, and the kinds of waiting lists and hoops that people had to jump through in order to get any psychological provision. But at the same time I worry that IAPT can sometimes act as a façade for services and commissioners to say that they're providing care, when actually what you need is not being provided. And part of that is to do with CBT and fidelity to the actual model of what is actually being provided. A large part of that is to do with access issues, and what Participant C said about the waiting lists is absolutely crucial. I did a Freedom of Information request because so many of my patients were not receiving treatment, yet I was told that they were all meeting waiting time standards. So there is a fudge. The fudge is that they receive their assessment within the waiting time standards, and then they're told that there will be months before the therapy actually starts. A lot of my patients have PTSD, PTSD's a hugely complicating factor when it comes to chronic pain, and I've had patients who've had 10 episodes of EMDR or trauma focused CBT and the therapists says you need to have another 10 sessions because it's so complex, but your time with me is up we were only allowed to give you 10 so you'll have to go back on the waiting list and come back. And I carry on seeing the patient and there is another year long waiting list, and by the time they go back they now need 20 sessions of CBT, whereas if they'd just had it at the start then it would have been so much more cost effective. So, the waiting time standards is absolutely crucial. On the issue around the long-term conditions, as I say my patients have pain conditions, and many times when I refer patients to IAPT services, the practitioners will say we're not sure how to manage the pain, a lot of this appears to be around their opioid misuse or whatever it might be. And we've had conversations in which we've said we'll manage the pain, we'll manage the opioids, can you just provide the therapy? We'll do training sessions together, we're happy to see the patient with you, or you come and see the patient with us here and I don't know what it is, whether it's bureaucracy but there just seems to be some sort of barrier to do that. The long term conditions appears to be around things like COPD and diabetes and asthma, which is important, by all means it is important, but Jane Dacre was saying that there was Anita Charlesworth and John Appleby were on the panel, and at the Health Foundation they released a report last year looking at the UK population with common mental health conditions depression and anxiety, and the most common long term condition that they had was a chronic pain/muscular skeletal condition, far above diabetes or asthma. Despite this, I don't think it's given as much emphasis or focus as the other long-term conditions are.

Alex Lloyd: Thank you, that's hugely insightful. One thing that I think I'd like to pick up on that I think relates to your points there, and also something that Participant A was saying earlier, is about the threshold that it takes in order to be seen by IAPT. So do you feel as though those- it sounds like they have improved from when you were in training- but do you feel like they're accessible. Whether it's to do with long term conditions or IAPT in general, do you feel as though the severity or the scale of the acuteness of what the patient is going through is appropriate, or do you think that it is maybe misjudged. Participant C, would you like to go first?

Participant C: So the threshold set for the original IAPT service is being above the clinical cut-off point on the PHQ9 depression measure and the GAD-7 anxiety measure, so anybody who is above a score of 10 for depression, and above 7 for anxiety meets the threshold. We did the national audits and everybody coming into the IAPT service meets those thresholds. There isn't, as it were a problem, of not being able to access the service because the service is creating too high a threshold for people. However, there is a problem with people getting from referrals, or self-referrals, into treatment. Consistently, year on year, as the annual IAPT reports show, there's a drop off of around 20-30% of the total population being referred in who don't even make it into the initial triage

session that Participant E is talking about, which is then as it were counted as having started treatment which is the fudge. There's about another 20% or so who drop off after the triage, so you're ending up with 40-50% of that total cohort who need help, and who qualify for help, but aren't actually getting help. So that's been a problem right from the outset and it's never been solved. It's partly to do with the way that IAPT is set up as a kind of standalone service that isn't integrated with either primary care, or indeed any kind of liaison psychiatry either, so it kind of exists in a separate silo and that's part of where the losses are happening. And obviously, the long-term conditions programme was meant to then kind of help move that back in, help to integrate, which was the question that you asked at the start Alex. Are the practitioners being co-located more in primary care services? They are, but because the communication systems aren't there, there is no communication unless the individual practitioner and the individual GP happen to be able to cross paths, which they can do obviously, but it's easier with co-location. But at a system level there isn't the communication, because typically the different IT systems don't communicate with each other so you can't follow a patient. If you were sitting in the GP surgery and you want to know what is happening with your patient, you simply can't access that information. Participant E couldn't access the information from where he is, nor can the IAPT practitioners likewise access the GP EMIST type systems to know what else is going on. So that's one of the big problems that hasn't been solved to do with a joined-up approach.

Participant D: I just wanted to agree with all the comments made by Participants E and C, and to add another big concern that we as an organisation have, and that is the very mixed and patchy level of integration and communication with existing clinical health psychology services in the acute hospital trusts. In an ideal world you would want there to be a strong relationship with clinical health psychologists who exist presently, and have done so for the last 20 years, to deal with long term conditions. Suddenly IAPT decides it's going to get involved but doesn't always think of getting in touch with the existing psychological service for people with long term physical health conditions. So that's yet another complication. For there to be proper integration and seamless care pathways that involves both existing clinical health psychologists, as well as IAPT, would really be in the best interest of the patient.

Participant E: I think the integration aspect is really key. That's part of the reason why we've tried to do these joint teaching sessions or joint learning sessions with out local IAPT services in an effort to try and integrate. The issue around having separate patients record is a really big one actually. In my local authority, they are in this programme of having something called a Health Information Exchange, which means all providers of healthcare services, including GPs, will be able to see various records of each other, it's a new-fangled wizardry that astounds me, but just thinking about it I don't think that I would be able to see IAPT records through that. I suppose I would have some access to it through general practice records or not as Participant C is shaking his head. So that is really important, and I wonder what the commitment for integrating mental health is in these ICSs that are coming up. There is lip service, at least, paid to it but I haven't seen any defined commitments from any of the ICS policy records that I've seen in which there is a dedicated commitment to integrate with mental health, and that includes specialist mental health services along with primary care services. And there are models of good practise. In a local authority near me, which was a mental health trust, but it has become a health trust and it does a range of community services and a result of that IAPT has come under it's umbrella. It's got something called a Community Integrated Care Service. I have heard good things about it, but as a model at least it seems to be an exemplar that we could be learning from. I'm not saying that everywhere needs to do the same thing, but you also don't need to reinvent the wheel but there are ways of approaching this at a systemic structural level.

Participant A: Just a couple of points to follow on from that. Back to the stepped model, I'd just reiterate what Participant D said about the downsides to that and the need for someone with the skills being at the beginning of the process. Another factor that's part of that is just the repeated experience of failure that some of our service users have. If they come into that process with very complex needs, they're not fast-tracked to the service that needs to see them, they have to fail at three different points before they can get to it. And I think that explains some of the drop off, for our lot anyway who are expecting that kind of rejection and they're quite quick to drop out of the services. So I think that will be an improvement. Regarding communication between IAPT and other specialist services, in our trust we've recently moved our EPR system to the same one that a lot of the local GPs use, System One. Which is a good move, not all GP surgeries are signed up to it and not all patients consent to their records being shared, but when it is there it can be really useful to have access to what is going on. I think the main point I just want to make is that this reminds me of CPA, and that need for care coordination for anyone with complex needs in the community. The service that I work in is a small team for people with forensic support needs in the community with learning disabilities. Most of them are open to multiple agencies, including criminal justice, and whatever we call it, whether it's CPA in health or local authority the care-coordinator role is key for facilitating stuff, and greasing the wheels, and something like that would seem to be important for anyone leaving inpatient care, or who needs care from two systems that aren't at the moment talking to each other very well. In the absence of all the electronic wizardry to allow it to happen, having a care coordinator's a quick fix. It takes time, but it can work wonders if you've got the right person doing it.

Alex Lloyd: Thank you very much. Participant D, I'll take your point and then we'll move onto our next question as we've got a couple more things to touch on later on. But we can also come back to this later on.

Participant C: The stepped care model was based on the 2009 depression guideline, although there was a sort of review with the IPAT programme before that, but basically the model is what features in the 2009 depression guideline for stepped care. It has become, what I would call a fail first model. You have to fail at least one, or sometimes more, intervention before you have a chance of getting anywhere near the intervention that you actually might need because of the way that it's structured. Americans call this cookie-cutter care, that you effectively just plant a shape on whoever comes through the door, and I'm afraid that's also the care for the long-term condition approach, it's the reason why I think Participant E is getting frustrated with the service. There is an inability to take a personalised approach where the complexities and the co-morbidities and the different social contexts are looked at properly, not just by the individual but within a small team of people. Things are thought about before, there is then a decision about what the right intervention is. So it's going back to what Participant D was saying earlier, where there is an expert approach before you head off down the track. I very much support that. I also just want to make another point to come back to what Participant A was saying. It is a scandal that the service still discriminates against people with learning disabilities. They actually discriminate against older people also, they started off officially doing that because some of them put an age limit on their service and then were told that they couldn't do that, but it hasn't made much difference because the figures show that hardly any older people are accessing IAPT services. And actually the same goes across different ethnic minorities, they are largely under-represented, men as well are by and large under-represented, LGBT groups are likewise under-represented. The majority of service users, the single biggest group, are young white women who are accessing the service for depression and anxiety, and they're not doing great actually. Their levels of self-harm have been going up increasingly since IAPT began 10-15 years ago. So, the group that actually get the service in terms of the burden of depression or anxiety don't

seem to be overtime reducing that burden, and large groups of the rest of the population, particularly the ones who have long-term unemployment and chronic and recurrent depression are just not getting access at all where the issues are more complex. Or where there is any kind of suicidal risk as that is used as an exclusion criteria. So we're not providing access to the whole population, and again the long-term conditions programme hasn't really changed that.

Alex Lloyd: Thank you. And one of the things that we're hoping to recognise in this report are the disparities in the provision of mental health services, so thank you for all of your comments so far. The next question that I want to ask is whether you think that the funding has been sufficient in order to properly invest in these services and make progress on these commitments. I appreciate that you don't all work exactly in these services, but from your perspective when it might come to the integration of services or the communication between services, do you think that the funding has been sufficient to really make progress on that commitment i.e. the integration of long-term condition services into IAPT.

Participant C: Sorry, but how would we know Alex? They just don't publish the breakdown. It's a straightforward matter, for what were the CCGs, to have published what they're spending. We know that Simon Stephens has got the figures, Claire Murdoch has got the figures and we've asked for the figures, but they just refuse to publish them. So how do we know? The rest of us actually need to know if we're going to answer the question that you've asked, and to hold them to account for the money that the Treasury agreed and is sitting there in the pot. £2.3 billion for mental health and allocation to IAPT within that. So I find that very frustrating, that the figures just aren't published. The way we do know that they've been underfunded however is that we've got the last IAPT workforce census. That showed that three quarters of the services around the country say they are providing long term condition service of some kind, so we know that they're not meeting the requirement around access, the trajectory that I talked about to get to 1.6 million that's if you don't consider all the drop off issues. And the other reason that they're not adequately resourced is in terms of staffing, and I don't just mean numbers of staff I also mean staff with the right levels of expertise and the right seniority within the services. In our latest staff wellbeing survey- we've been doing an annual staff wellbeing survey for psychological services now since 2016 when it all started to go pear shaped- 50% of the psychological staff are reporting that they themselves are depressed and the levels of burnout and indeed attrition are very high. The sickness absence rates are significantly higher than in other NHS services generally, so we're really not looking after the staff that are there and the targets regime is partly what's causing burnout.

Professor D: I just wanted to make a comment about clinical psychology services in secondary care. Something as an organisation that we're increasingly worried about, and it seems this only applies to NHS England, it doesn't apply to NHS Scotland, Wales or Northern Ireland, especially since 2008 and the era of austerity and reduced funding generally to all trusts, there has been an overwhelming tendency for trusts to get rid of senior clinical psychologists. So where clinical psychologists of the higher grades are retiring, they're almost always replaced with very junior people. The consequence of this is what you create is completely flat service structures with no proper accountability and supervision, at least in terms of individuals with the necessary expertise. Also, for those existing people who want to remain in the NHS, and I have to tell you over the last few years there has been a very significant exodus of clinical psychologists into the private sector because there are no career pathways in England. So there are now very few consultant grade clinical psychology posts available for people to apply for, and as far as I can see there has been no attempt by central government to influence this trend. I'm not entirely sure why it's not happening in Scotland or Wales, but it may have something to do with a sense of their being more resourcing for adult mental health. That for

me is a major concern, and if there was a way that we could influence government to put a stop to this and to start creating more senior levels within clinical psychology I would be very grateful and that would actually be in the best interests of patients and clients.

Alex Lloyd: Thank you very much. I'd just like to pause here to introduce Participant F who has just joined us. So Participant F, we are talking about adult common mental illness and we're specifically discussing the government's commitment to integrate long-term condition services in IAPT. I don't know if you want to briefly introduce yourself, and we'll continue the conversation from there.

Participant F: Thank you, that's very kind and I apologise for arriving late. I was originally a civil servant and I retrained as a psychotherapist, that's' what I do now. I work in private practise and previously worked in an agency setting.

Participant E: I want to turn the funding question on it's head because I think that's the way that we are going. When Participants C and D were talking what I was thinking was what are we actually funding, what is the IAPT funding for, and that's for therapists isn't it? That's the main thing that the funding would be for. So my question, is and I don't know the answer to this, we have had problems with recruitment, massive problems actually, recruiting to psychology posts both senior and junior in our hospital, and are there enough psychologists out there to fund. The reason I come to this is because my experience in medicine is that the workforce plan has always been stuck on as an afterthought to any sort of policy decision such as with The Five Year Forward View, the NHS Long Term Plan, and then the NHS People Plan which came a few years after that. And when there is the thought of workforce planning it seems short-term: how do we get people into posts in the next 2-3 years. A medic takes 10 years and I'm sure a psychologist takes the same as that so there needs to be a long-term view on that as well, which is not added as an afterthought. So what are we funding?

Participant C: I can have a go at answering that. So the funding is really for two things. It's for the training because all the IAPT posts, either at low intensity or high intensity, come with a training and officially it used to be the case that for the first year you had the salary support and then the CCG as was would pick up the salary costs after the training year, and that went down to 60% of the salary cost which carries through to 2022/23. So the funding is both for the training, on the one hand, and then 60% of support for the salary. This is a huge problem within the professional field, which is quite fragmented, when you look at psychiatrists, psychologists, counsellors and psychotherapists as a whole, there are a lot of us actually. There's well over 100,000 of us and what is needed is a decent workforce planning strategic body- which is not Health Education England as that is just a disaster- to be able to bring together in a coherent way what the career development pathways for us, who each bring something different, different skills and attributes to the tasks that we're faced with in mental health. And possibly also more flexible attitudes around part time working, where people do want to offer their skills, where there is a particular pressure on demand. The big bodies should be able to draw bank staff in a flexible way so that we can meet the targets for access and not get into long waiting times. We now have waiting times which are six months, or 12 months in some areas. It's as bad as it ever was really. But I also just want to pick up the point that Participant D made. One of the reasons, and it's a scandal, why in England we have this flattening out process and frankly unsafe staffing levels is because these services are not inspected by CQC. I think this is a point that Robert Francis needs to pick up with Jeremy Hunt and with the Ministers. In no other area have you got hundreds of thousands of patients going through services where there is no inspectorate to decide whether it is safe or not. But that has been the case all throughout IAPT, that CQC do not inspect IAPT services and at the moment have no plans to.

Participant D: I wanted to also have a bash at answering the question around what we're investing in in terms of IAPT. Just to say that the supply of psychology graduates is very extensive, and it's unlikely that IAPT services, even with current expansions is going to exhaust the supply. Psychology is either the second or third most popular subject to study at university, and we know that about 40% of psychology graduates would like a career in health and social care- and most of these are pretty high calibre individuals. The big problem for IAPT, and for Health Education England, is that most of these graduates who get say PWP posts are not thinking of a career in IAPT or PWP, they're actually wanting to become clinical psychologists, and the problem is that the competition for the post-graduate training is so severe, that they know that they have an armful of PWP like experiences before they're going to get a good enough CV to get onto a doctoral course- or at least that's what they imagine. Within the last few weeks Health Education England put out a pronouncement that said that in future any individuals who have done any kind of psychological training, such as PWP, will be barred from going onto any further HE funded training for at least two years. The pandemonium that that created, and it took Health Education England completely by surprise because they didn't seem to have any idea of what's going on in terms of why psychology graduates are applying for PWP and low-grade psychological practitioner posts. Health Education is now trying to have a rethink about the general approach. But this is the reality of the situation, that we have this relatively untapped large resource of psychology graduates and as I say most of them are interested in a career in clinical psychology. I agree with Participant C's comment about the need for something other than Health Education England to have some kind of oversight of career pathways and manpower and matching all of these issues up in a way that Health Education England doesn't seem capable of.

Alex Lloyd: Thank you all very much for your comments. Really helpful. We've only got a few moments left, but the last question that I want to get your view of is around the appropriateness of this commitment. Was it appropriate for the Government to set out this commitment about whether or not long-term conditions should be integrated into IAPT and whether it is sufficient to meet the needs of service users?

Participant E: I think it was appropriate, I think it was a good move. The crucial element is in its execution, but I think the commitment is right and appropriate. IAPT is seen as a primary care based service, alongside general practise and pharmacy, and that is where the burden of long-term conditions is appropriately met and managed. It comes back to the previous point around integration with the other aspects of primary care, and I find it interesting that we're talking about common mental health conditions, but we don't have any GPs or pharmacists here, and that maybe speaks to the integration element. I think there also needs to be a recognition that long-term conditions come in fits and waves. The vast majority of times they're appropriately managed in the community settings, but there will be times, no matter how hard you look after someone, that they will get a diabetic crisis, or for the kinds of patients that I see their pain will get unmanageable and they will have to come into tertiary care. I don't know whether if this is because I'm at the receiving end of it, but I sometimes feel that from a commissioning perspective that is seen almost as a failure, that something has gone wrong in the pathway, and this person now needs hospital care which is the more expensive end of healthcare, and its assumed we should have done something to stop that from happening. I think those questions are appropriate, but that doesn't take away from the reality that long-term conditions, common mental health conditions also require hospital and specialist management. I know that this is true actually because I've had discussions with commissioners and there is a sense that we need to put everything into primary care and general services and by doing that we don't need to fund other services. As I say we're not funded, our psychology service is not funded to provide outpatient care, that should now be taking up by IAPT LTC, but IAPT LTC is saying

that we don't have the requisite expertise to look after these patients. So the patients are caught between a rock and a hard place. And it's not just pain, it happens up and down the country with all sorts of conditions. So the focus can't just be on primary care. Yes, absolutely, long-term conditions is the right initiative to take forward, and common mental health conditions are complicating factors, but they are also complicating factors who've had their 15th, and that's not an exaggeration, hip surgery in a hospital.

Participant C: I think it was partly the right thing to do in terms of the intention to provide an integrated model with primary care and GPs involved, it that was the aim. But it was certainly the wrong implementation, and I would say the wrong leadership actually in terms of how it went about the job. The false assumption, however, is that these long-term conditions are these discreet conditions that just exist on their own and also not recognising that for large numbers of people depression is a long term and recurrent condition. It might not always be severe or complex, but nevertheless recurrent dysthymia is very common, and we also know that because there are large numbers of people on long-term anti-depressant treatment, possibly more than there should be if the IAPT service were functioning properly. It was partly the right idea, but I should also say that it was to get away from a terrible failure in the original programme which said that it would get people on unemployment and invalidity benefits back into work, and that was how the programme was going to pay for itself. That population group do have lots of long-term health conditions, in addition to chronic depression, and IAPT just completely failed to be able to address those problems. The employment support side of things never worked and the idea that within 6-8 sessions of CBT (the average was 7) you were going to help people turn their lives around and get back into sustained employment was a nonsense. So, I'm not attacking CBT therapists at all, when they're brought in at the right time and in the right way that can be extremely effective, but you need the continuation of care. If you're going to talk about long-term conditions you need continuity of care and IAPT doesn't have that, it's in and out. It's still the same model of quick in and quick out in order to meet the access targets. So I'm afraid the implementation just didn't work.

Alex Lloyd: We're going to hear one quick comment from Participant A and then I'm afraid we're going to have to wrap up. But before we finish, I just want to say thank you, it's been really interesting to hear your conversations that would be really great use to the work of the expert panel.

Participant A: I'm just going to follow on from what Participant C just said and hark back to coordinated care. People with complex needs, need that their care coordinated. So that allows for a flexible approach, it allows one person to have some oversight and to bring in others when they're needed but it keeps some continuation of the care. It works well when it is done well.