Potentials and drawbacks of the IAPT model: Insights from service user and clinician

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This paper offers a critical analysis of the Improving Access to Psychological Therapies (IAPT) model by drawing on both clinical and lived experience. It highlights the programme's key strengths, including reduced waiting times, broad geographic coverage, routine outcome monitoring, and a strong emphasis on cognitive behavioural therapy. These features have contributed to the model's widespread adoption and have improved access to psychological support across the UK. In addition, IAPT's patient-centred ethos promotes flexibility and service user empowerment through collaborative goal setting, varied delivery formats, and responsiveness to client preferences. However, the paper also identifies significant limitations. Regional disparities, a narrow range of therapy options, rigid session structures, high service demand, and clinician burnout present ongoing challenges. These issues are further compounded by systemic constraints, including funding shortfalls and workforce pressures, which threaten service consistency and sustainability. The paper argues that while routine monitoring improves accountability and clinical outcomes, it may also contribute to administrative burdens and increase pressure on both practitioners and clients. The analysis draws on practitioner accounts and service user feedback to explore these dynamics in depth. It advocates for targeted reforms, including increased funding, the introduction of more diverse and culturally sensitive therapies, and flexible treatment frameworks tailored to client complexity. Recommendations also include workforce support strategies such as protected supervision time and professional development opportunities to mitigate burnout and promote staff retention. The paper concludes by calling for a more adaptive and inclusive model of care that remains true to IAPT's foundational aims while addressing the realities of rising demand and diverse service user needs. Ensuring equitable access to high-quality mental health support requires not only system-level changes but also a commitment to ongoing research and user-led innovation.

Keywords: improving access to psychological therapies; mental health services; psychological therapy; service user experience; workforce challenges

The Improving Access to Psychological Therapies (IAPT) programme was launched in England in 2008 to expand access to evidence-based interventions for common mental health conditions such as anxiety and depression. By prioritising early intervention and standardised treatment protocols, IAPT has become a cornerstone of primary mental health care in the UK. While its reach and outcomes have been widely reported, much of the existing literature focuses on service metrics rather than the detailed experiences of those who deliver and receive care.

This article addresses that gap by offering two perspectives on IAPT. It presents the viewpoint of a mental health clinician who has also accessed the service as a user, alongside reflections from a trainee clinical psychologist who has worked within the IAPT system. By combining lived experience with clinical insight, the article explores both the strengths and limitations of the model, focusing on access, treatment structure, and staff well-being. In doing so, it offers a grounded and practice-informed analysis of how IAPT functions in everyday settings, particularly for marginalised populations and frontline practitioners.

Potentials of the IAPT Model

Reduce waiting times

One of the core aims of the Improving Access to Psychological Therapies (IAPT) programme is to minimise delays in the provision of psychological interventions (Smith, 2022). By increasing entry points into mental health services, the programme has made notable strides in improving access to care for individuals experiencing anxiety, depression, and related conditions (NHS Digital, 2022). This emphasis on early intervention is intended not only to enhance clinical outcomes but also to reduce broader systemic costs associated with long-term treatment, frequent healthcare use, and workplace absenteeism (NHS England, 2021).

Practitioners working within IAPT services have observed that reduced waiting times for initial assessments contribute significantly to the programme's overall efficiency. The dedicated structure of IAPT as a primary care mental health service has helped alleviate pressure on secondary care by providing timely support for individuals with mild to moderate mental health concerns. However, despite improvements at the initial entry point, delays between assessment and the start of therapy remain a concern (Smith et al., 2021). Service users frequently experience waiting periods ranging from several weeks to months, which raises questions about risk management during this interim period.

In some instances, individuals with professional experience in mental health services who later engage with IAPT as service users report a lack of structured interim support while awaiting treatment. This highlights a potential gap in care continuity, particularly for those at heightened risk. Addressing this issue may require the development of standardised signposting practices or access to digital self-help tools designed to provide temporary support and prevent deterioration prior to treatment onset.

Geographical reach

The national implementation of the Improving Access to Psychological Therapies (IAPT) programme has aimed to ensure that psychological support is accessible across all regions of the UK (Wakefield et al., 2021). This widespread availability represents a key strength of the model, as it allows individuals in both urban and rural settings to seek evidence-based mental health interventions. However, while service coverage has improved overall, the degree of accessibility remains uneven across different geographic and demographic contexts (Clark, 2021).

Practitioners have reported that the structural design of IAPT facilitates flexible referral processes and accommodates diverse client needs through various treatment formats, including one-to-one therapy, group sessions, and digital platforms such as SilverCloud. The inclusion of early morning and evening appointments has also improved access for individuals with work or caregiving responsibilities. These adaptations support the programme's goal of making therapy more inclusive and responsive to service user constraints.

Nevertheless, disparities persist, particularly in rural areas and socioeconomically disadvantaged communities, where shortages of trained clinicians and longer wait times continue to limit timely

access to care. Additional barriers, including language difficulties and cultural mismatches between clients and therapists, further impact engagement for some populations. These challenges highlight the need for more targeted interventions to address regional inequities in service delivery.

To strengthen equitable access, the IAPT model would benefit from increased investment in workforce capacity, expansion of culturally adapted interventions, and systematic evaluation of regional performance. Interim support options, such as structured self-help tools, may also serve to bridge care gaps for those facing prolonged wait periods.

Evidence-based treatments

A central component of the IAPT programme is its commitment to delivering interventions that are grounded in empirical evidence. Cognitive Behavioural Therapy (CBT) remains the dominant modality within the service and has been extensively utilised to treat a range of conditions including generalised anxiety disorder, depression, post-traumatic stress disorder, obsessive-compulsive disorder, and various phobias (Sansom et al., 2021). The programme's emphasis on manualised, protocol-driven interventions aims to standardise care and improve treatment fidelity across service sites.

Practitioners working within IAPT have highlighted the versatility of CBT in addressing both common and complex presentations. Additionally, the scope of IAPT has expanded to include health psychology applications, such as supporting individuals with long-term health conditions and perinatal mental health concerns. This broad applicability reinforces the programme's efficiency and scalability.

Despite these strengths, concerns have been raised regarding the limited range of therapeutic modalities routinely available within IAPT. Service users report that while the emphasis on evidence-based practice is valuable, the predominance of CBT may not align with the needs or preferences of all clients. In some cases, individuals have undergone multiple assessments before being matched to an appropriate intervention, which may contribute to service fatigue and delay the start of effective therapy. To address this limitation, the adoption of an extended assessment model could help streamline referral processes and reduce unnecessary duplication. Furthermore, expanding the availability of alternative evidence-based approaches (e.g., dynamic interpersonal therapy, counselling for depression, or other NICE-recommended modalities) may enhance both engagement and treatment outcomes for individuals whose presentations are less suited to CBT.

Addressing treatment gaps

While the IAPT programme has achieved wide-scale implementation of evidence-based therapies, particularly CBT, concerns persist about the limited diversity of available interventions. The narrow therapeutic focus may restrict the programme's capacity to meet the complex and varied needs of its service users, particularly those whose difficulties do not align well with a CBT framework.

Several additional modalities, although supported by evidence, remain underrepresented within routine IAPT provision. These include Acceptance and Commitment Therapy (ACT), which has shown promise for individuals coping with chronic physical health conditions and experiential avoidance; Eye Movement Desensitisation and Reprocessing (EMDR), which is particularly effective for trauma-related disorders; and other approaches tailored to specific cultural or community needs. The integration of such models would not only expand the programme's clinical utility but also support the personalisation of care.

Service data and user feedback suggest that many clients would benefit from therapeutic options that better reflect their lived experiences, particularly those from minoritised ethnic backgrounds. Cultural adaptation of treatment protocols and increased therapist diversity have been identified as factors that may enhance therapeutic engagement and outcomes in these populations.

To reduce existing gaps in treatment coverage, IAPT services could consider piloting a broader range of interventions in line with NICE guidelines. Training clinicians in multiple modalities and expanding commissioning frameworks to include non-CBT therapies would represent a meaningful step toward improving both accessibility and clinical relevance across diverse service user groups.

Outcome monitoring

Routine outcome monitoring is a defining feature of the IAPT programme and plays a key role in service evaluation and clinical decision-making. Standardised measures such as the Generalised Anxiety Disorder Assessment (GAD-7), the Patient Health Questionnaire (PHQ-9), and the Work and Social Adjustment Scale (WSAS) are used consistently across sessions to assess symptom severity, track progress, and inform treatment planning (Clark, 2018).

This systematic approach to data collection allows services to monitor recovery rates, identify trends across client populations, and adjust delivery models based on aggregated findings. From a clinical perspective, the regular use of validated tools supports transparency, accountability, and responsiveness in therapy. Practitioners are able to gauge the effectiveness of interventions in real time, enabling timely modifications to treatment plans when progress is limited.

However, concerns have been raised about the psychological impact of frequent measurement on service users. Some clients report feeling anxious or pressured by the expectation to demonstrate improvement through numerical scores, which may influence the way they respond to these instruments. For practitioners, the administrative demands of routine data collection can add to workload pressures and potentially disrupt the therapeutic flow of sessions.

While outcome monitoring remains essential for ensuring service quality and accountability, its implementation should be balanced with clinical sensitivity. Efforts to contextualise scores within a broader understanding of the client's experience, and to communicate the purpose of monitoring clearly, may help mitigate adverse effects and enhance therapeutic rapport.

Economic benefits

The IAPT programme was designed not only to improve access to psychological therapies but also to reduce the economic burden associated with untreated mental health conditions. Early intervention for common disorders such as anxiety and depression can result in decreased healthcare utilisation, reduced reliance on long-term medication, and improved workplace productivity (NHS England, 2021).

Service-level data indicate that IAPT has achieved measurable efficiencies through structured, protocol-driven care. Reported recovery rates, including the attainment of the 50% recovery target in many regions, support the view that the programme delivers clinically effective outcomes at scale. This aligns with broader NHS policy objectives, such as those outlined in the Five Year Forward View, which emphasise integrated primary care solutions as a means of reducing strain on specialist services.

The economic rationale is further reinforced by the cost-effectiveness of brief psychological interventions when delivered in a standardised format. By diverting service users away from more resource-intensive secondary care pathways, IAPT helps contain system-wide costs while still offering support for a large volume of clients with moderate mental health difficulties.

However, questions remain about the sustainability of these gains in the context of rising demand and workforce limitations. Maintaining cost-effectiveness will require ongoing investment in staffing, infrastructure, and outcome evaluation, particularly in areas where access remains uneven. Strategic resource allocation based on local need will be essential to preserve the programme's economic viability while ensuring clinical quality.

Patient-centred approach

A core strength of the IAPT programme lies in its emphasis on delivering care that is tailored to the individual needs of service users. From the point of initial assessment, the programme seeks to involve clients in collaboratively setting treatment goals, often structured using SMART criteria. This approach encourages shared decision-making and supports greater autonomy in the therapeutic process. Flexibility in delivery format is another dimension of IAPT's patient-centred model. Services routinely offer a range of options, including face-to-face sessions, guided self-help, group

interventions, and digital therapies. Many services also provide appointments outside standard working hours, which increases accessibility for individuals with employment or caregiving responsibilities.

Attention to client preferences extends to therapist characteristics, with some services accommodating requests based on gender, cultural background, or language where staffing allows (Ilagan & Heatherington, 2022). Such adjustments can improve engagement and foster a stronger therapeutic alliance, particularly for service users from marginalised or underrepresented communities. Although these features contribute to a more inclusive and responsive service, practical limitations such as staffing constraints and regional variation in resources can affect the consistency of this personalised care. Ensuring that patient-centred practices are embedded across all IAPT sites requires both structural support and ongoing training in cultural competence, trauma-informed care, and equity-focused service delivery.

Empowerment and engagement

Service user engagement and empowerment are central to the IAPT programme's operational ethos. The model actively encourages clients to take an active role in their care through collaborative goal setting, structured feedback processes, and involvement in service evaluation initiatives. These elements are designed to enhance motivation, strengthen the therapeutic alliance, and support sustained recovery.

Structured mechanisms for gathering service user feedback, such as focus groups and patient panels, provide opportunities for individuals to influence service development (Gallegos et al., 2023). In some services, former clients have contributed insights that have informed improvements in accessibility, communication practices, and session formats. This participatory model aligns with broader NHS priorities around co-production and continuous quality improvement (Kapadi, 2023).

Engagement is further supported by the programme's emphasis on psychological education and skill-building. Clients are typically encouraged to practise strategies outside of sessions, reinforcing self-efficacy and promoting long-term resilience. This structured involvement can lead to improved clinical outcomes and a greater sense of ownership over the therapeutic process.

However, meaningful engagement requires more than procedural inclusion. For empowerment to be sustained, services must ensure that user input leads to tangible change and that diverse voices (including those from underrepresented groups) are equitably heard and integrated. Embedding these principles across all levels of service design and delivery remains a key area for ongoing development.

Drawbacks of the IAPT model

High demand and resource constraints

Despite its widespread implementation and positive reception, the IAPT programme continues to face significant challenges related to high service demand and limited resources (Martin et al., 2022). Although the programme has improved access to psychological therapies at the initial referral stage, service users often experience substantial delays between assessment and the commencement of treatment. These waiting periods can range from several weeks to months, depending on regional capacity and staffing availability (van Ginneken et al., 2022).

Delays of this nature risk disengagement from services, particularly among individuals experiencing fluctuating motivation or complex personal circumstances (Shukla et al., 2022). In some cases, extended wait times may contribute to deterioration in mental health, potentially increasing the severity of presenting problems by the time treatment begins. The gap between assessment and intervention has been consistently identified in service evaluations as a point of vulnerability within the care pathway. Efforts to mitigate these effects have included the provision of interim options such as group-based interventions or digital therapies (Whittingham et al., 2023). While these may offer temporary relief and preserve engagement, they are not always perceived as adequate substitutes for one-to-one support, particularly for clients with specific or sensitive difficulties. Ensuring that such interim provisions are clinically appropriate, clearly explained, and readily available is essential to maintaining service user trust and preventing escalation of symptoms.

Addressing these pressures requires both increased investment and more adaptive service design. Resource allocation must be responsive to local demand, and workforce planning should prioritise retention, training, and flexible service models that can absorb fluctuations in caseloads without compromising care quality.

Systemic challenges

The effectiveness of the IAPT programme is shaped not only by clinical practices but also by wider systemic factors, including funding structures, workforce distribution, and policy directives. In many regions, persistent underfunding and resource constraints limit the programme's ability to deliver consistent and comprehensive care. These limitations are particularly pronounced in high-demand areas, where services may be forced to restrict the number of available sessions or limit access to certain therapeutic modalities.

Clinicians working within IAPT frequently report challenges related to session caps, which can constrain therapeutic flexibility and create pressure to demonstrate progress within a fixed timeframe. This is particularly problematic for service users with complex needs or those who do not respond predictably to short-term interventions. While outcome data may reflect broad service efficacy, such metrics can obscure individual cases in which rigid structures hinder personalised care. Experiences shared by service users who have accessed therapy both within IAPT and through alternative systems further highlight the limitations imposed by fixed session models. Compared to more flexible frameworks, such as those found in some private or international healthcare systems, IAPT's approach can feel prescriptive and overly focused on efficiency. However, when clinicians are able to apply professional judgement and extend care based on individual progress, outcomes tend to improve.

To overcome these systemic constraints, the programme would benefit from more adaptable commissioning models, expanded session frameworks for specific clinical presentations, and policy support that prioritises clinical autonomy (Sandom et al., 2022). These adjustments would enable IAPT to better meet the needs of a diverse client base without sacrificing service integrity.

Interplay between funding and demand

The relationship between rising demand for psychological services and constrained funding represents a central tension within the IAPT model. As mental health awareness increases and public attitudes toward help-seeking improve, more individuals are accessing services. However, funding levels have not consistently kept pace with this growth, resulting in service bottlenecks, staff shortages, and pressures to prioritise efficiency over flexibility.

These financial constraints often necessitate strict session limits and reduce the availability of specialist interventions. In turn, this can lead to a one-size-fits-all approach that may not meet the nuanced needs of diverse client populations. Regions with high levels of social deprivation or limited local infrastructure are particularly vulnerable to these limitations, which can exacerbate existing health inequalities and further widen the treatment gap.

Moreover, resource pressures frequently compel services to make short-term decisions, such as streamlining assessments or limiting follow-up contact, in order to meet throughput targets (Chiwawa & Wissink, 2024). While such strategies may improve quantitative performance indicators, they can compromise therapeutic continuity and diminish the quality of the service user experience. To resolve these tensions, strategic investment is required to support scalable, needs-led service models. Equitable funding distribution based on demographic and geographic indicators, coupled with the integration of flexible treatment pathways, would allow IAPT to meet increasing demand without compromising care quality or accessibility.

Professional burnout and workforce challenges

The sustainability of the IAPT programme is closely tied to the capacity and well-being of its workforce (Jones et al., 2023. Although the model is supported by standardised training pathways and supervision structures, staff retention remains a persistent challenge. High caseloads, administrative

burdens, and performance-related pressures contribute to elevated stress levels among clinicians, particularly Psychological Wellbeing Practitioners (PWPs) and High-Intensity Therapists.

Reports from within services indicate that practitioners are frequently required to deliver a high volume of back-to-back sessions, often with limited time for reflection, supervision, or professional development (Last et al., 2024). This intensity can lead to emotional fatigue, reduced clinical effectiveness, and, in some cases, premature departure from the workforce (Dey & Relojo-Howell, 2021). Such turnover has direct implications for service continuity and contributes to the cycle of staffing shortages.

Workforce pressures are further compounded by limited opportunities for career progression and the perception that clinical judgement is often subordinated to service targets. While training in evidence-based modalities is typically comprehensive, the emphasis on protocol adherence can leave little room for the development of broader therapeutic competencies or innovation in practice.

To support workforce sustainability, targeted strategies are needed to address practitioner well-being, including protected time for supervision, access to peer support, and realistic caseload expectations. In addition, investment in career development pathways and greater clinical autonomy could improve retention and enhance the quality of care. Supporting staff in these ways is essential not only for professional well-being but also for maintaining the overall effectiveness and integrity of the IAPT model.

CONCLUSION

The IAPT programme has significantly expanded access to psychological therapies across England, offering standardised, evidence-based care to individuals with common mental health conditions. Its strengths lie in its wide geographic reach, emphasis on routine outcome monitoring, and commitment to delivering patient-centred interventions. The integration of structured pathways and scalable delivery formats has allowed IAPT to operate efficiently within the context of primary care.

However, the findings presented in this article highlight persistent limitations that affect the programme's overall impact. High service demand, rigid session frameworks, limited treatment diversity, and workforce pressures continue to pose barriers to equitable and effective care. These challenges are particularly evident in regions with under-resourced infrastructures and among service users with complex or culturally specific needs.

Drawing on both practitioner and service user perspectives, this analysis suggests that further progress will depend on targeted policy reforms, increased funding, and the expansion of flexible, needs-led service models. Addressing these areas is essential not only to preserve the programme's core strengths but also to ensure that IAPT remains responsive to the evolving mental health needs of a diverse population.

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