Mind Supported Self-Help Intervention Evaluation

**Final Report
September 2025**

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Contents

List of acronyms

CBA: Cost Benefit Analysis

CBT: Cognitive Behavioural Therapy

CCA: Cost-Consequence Analysis

CUA: Cost-Utility Analysis

DSM-IV: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition

EQ-5D-5L: EuroQol-5 Dimensions-5 Levels

FTE: Full Time Equivalent

GAD-7: Generalized Anxiety Disorder-7

GP: General Practitioner

HRQoL: Health-Related Quality of Life

IAPT: Improving Access to Psychological Therapies[1]

ICER: Incremental Cost-Effectiveness Ratio

ITT: Intention To Treat

LEAP: Lived Experience Advisory Panel

NICE: National Institute for Health and Care Excellence

NMB: Net Monetary Benefit

PHQ-9: Patient Health Questionnaire-9

PMM: Predictive Mean Matching

PSA: Probabilistic Sensitivity Analysis

QALY: Quality-Adjusted Life Year

RCT: Randomised Controlled Trial

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[1] As of January 2023 this has been renamed NHS Talking Therapies: https://nhsrho.org/news/nhs-talking-therapies-review-identifies-barriers-in-accessing-care/

SSH: Supported Self-Help

SWEMWBS: Short Warwick-Edinburgh Mental Wellbeing Scale

WSB: Wider Societal Benefits

WTP: Willingness To Pay

Executive Summary

Introduction

Mind's Supported self-help (SSH) programme offers mental health support to adults over 18 experiencing mild to moderate anxiety, low mood, or self-esteem issues. Grounded in Cognitive Behavioural Therapy (CBT) principles, it provides an assessment and five intervention sessions, (and a further sixth session for signposting which clients can choose whether or not to attend) with dedicated practitioners hired and trained for the programme, delivered face-to-face or virtually.

Welsh Minds started delivery of SSH in October 2022 but implemented a digital system which started accepting referrals from August 2023 to March 2024 at 19 local Minds. In England, the programme ran from October 2023 to March 2025 at 27 local Minds. Mind collected data on 10,912 individuals that were referred to the service when the digital arrangement went live (from August 2023 onwards), of whom 9,528 attended an initial assessment at one of the local Minds funded to deliver the service. For this reason, Welsh data collection is limited as many referrals were accepted prior to the systems put in place. Local Minds can still deliver SSH, however central funding ceased in March 2025.

In Summer 2023, Mind commissioned Ipsos to undertake an evaluation of SSH. This evaluation aimed to determine:

1. The cost-effectiveness of SSH compared to a NHS waitlist control group, over a 12-month time horizon; and
2. The overall costs for delivering SSH over its lifetime from August 2023 to March 2025 and each type of outcome (consequences) it collected information on by the end of the 6-week programme.

The study has applied Cost-Utility Analysis (CUA) and Cost-Consequence Analysis (CCA) to answer these questions. The CUA in this context examines incremental cost per Quality-Adjusted Life Year (QALY) comparing this to the cost per QALY gained for a control group. The CCA provides a broader perspective, presenting all costs and outcomes associated with the intervention.

For this evaluation, the CUA compares clients for SSH to a control group of individuals on the NHS waitlist, comparing the incremental cost per QALY gained among SSH clients and the control group over a projected 12-month period. It also calculated wider societal benefits in terms of paid and non-paid work or contributions that clients with improved outcomes make to society, along with reduced consumption for care and public resources.

The CCA method presents all costs and outcomes relating to depression, anxiety, mental wellbeing and other NHS service use during the 6-week programme. Data for both methods comes from the IT systems Mind used in the intervention (Views and Limbic), capturing client demographics,

outcomes and service use. Data on programme costs was collected through separate IT systems (Flexigrant, Qualtrics).

CUA results

The CUA results demonstrate that SSH is both less costly and results in improved health related quality of life (HRQoL) over 12 months, compared to a control group of individuals on the NHS waitlist. The analysis includes costs for wider NHS service use alongside programme costs for SSH. It is considered less costly because, on average, individuals referred to it use fewer other NHS services than individuals on a NHS waitlist.

This means the intervention is **cost-effective** and 'dominant' relative to the control group.   The programme reports an Incremental Cost Effectiveness Ratio of -£167 per QALY gained, which is favourable. In this type of study, the ICER is considered cost-effective relative to a comparison group when it is below either £20,000 or £30,000, which is the value decision-makers are willing to pay for each QALY gained. This is the threshold recommended by the National Institute for Health and Care Excellence (NICE)[2]. In this case -£167 per QALY gained is well below this threshold.

The strength of the CUA results was tested by changing inputs or testing assumptions which contributed to the analysis. This helps to consider if the results will change by enough to affect the conclusion that SSH is cost-effective relative to a comparison control group. Methods which do this are called sensitivity or scenario analyses. Different approaches were carried out, including:

- changing assumptions or figures in the analysis one at a time (called one-way sensitivity analysis)

- creating a separate version of the analysis (called scenario analysis) with different rules in which (1) a greater number of individuals referred to Mind also use wider NHS services or (2) all variable costs covered in the CCA are also included in the CUA; and

- changing several inputs or assumptions at the same time, several times over, to see on how many occasions the analysis reaches the same conclusion regarding cost-effectiveness (called probabilistic sensitivity analysis).

The outcome of the CUA – in broad terms – and its overall recommendation remained consistent under each of these analyses. Beyond direct healthcare benefits, the larger HRQoL improvement in SSH also leads to wider societal benefits (WSBs) through improved productivity and reduced consumption of healthcare services, compared to the NHS waitlist control group. Adjusted for

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[2] Further information on NICE guidelines for assessing cost-effectiveness is available at
https://www.nice.org.uk/process/pmg6/chapter/assessing-cost-effectiveness

2023/24 prices, the WSBs of SSH are estimated at £27,240 compared to £20,512 for those on the NHS waitlist control group.

CCA results

Including all fixed and variable costs, the total programme cost was £3.5 million over its full lifetime from August 2023 until March 2025. This equates to £320 per client for all clients referred into the service. Costs were primarily driven by labour, accounting for 75% of the total programme cost, followed by IT costs at 11% of the total.

Setting up and licensing IT systems (Views and Limbic) was a significant decision by Mind which it has sought feedback on. Excluding IT, the total cost per client is £284. However, this study cannot confirm how removal of IT systems would affect service delivery.

The CCA then explored the consequences (outcomes) of the programme. This looked at mental and physical health and wellbeing measures for individuals, finding improvements from pre-intervention to session 5:

- SWEMWBS (Mental Wellbeing): An average 5-point improvement,
- EQ-5D-5L (Quality of Life): Average 0.11-point improvement.
- GAD-7 (Anxiety): Average 8.6-point improvement.
- PHQ-9 (Depression): Average 9.5-point improvement.

Additionally, the greatest improvements were seen from pre-intervention to session 3. There were still improvements from session 3 to session 5, though of a smaller magnitude. Following SSH, there was also reduced contact with GPs, outpatients and IAPT / Talking Therapies.

Key points

The result of the CUA demonstrates that SSH is a cost-effective intervention relative to a NHS waitlist control group for individuals with mild to moderate mental health issues, offering greater health improvements and reducing healthcare costs over a 12-month time horizon. This supports its potential adoption and maintenance within NHS mental health care pathways.

Mind can use these findings with a variety of internal and external stakeholders including funders, commissioners, policymakers, and delivery partners. The results also provide societal benefits and learnings for how Mind can deliver and undertake studies of the programme in future iterations.

1 Introduction

1.1 Introduction to the programme

Supported self-help (SSH) is a guided self-help service that has been developed and delivered by Mind. It offers free mental health support to adults experiencing mild to moderate mental health problems such as anxiety, low mood, or depression. It was designed in partnership with healthcare professionals to combat long waiting lists for talking therapies and aims to offer an alternative to prescriptions for anti-depressants. Based on cognitive behavioural therapy (CBT) principles and NICE guidelines, it includes an initial assessment followed by up to five one-to-one sessions (and an optional sixth session for signposting) with dedicated practitioners hired and trained for the programme, either face-to-face or virtually.

The sessions were designed to guide individuals through one of eight specific pathways. These are anxiety, depression, self-esteem, stress, feeling alone, anger, grief and loss, and menopause[3]. Each pathway included workbooks and self-management resources, grounded in CBT, aimed at equipping clients with practical tools and strategies to manage their mental health problems. The intended goal of these sessions was to empower individuals to improve their wellbeing and reduce the burden of mental health symptoms, improving their quality of life.

The rationale for introducing SSH is to provide accessible and timely mental health support for individuals who do not meet thresholds for NHS Talking Therapies (previously known as IAPT – Improving Access to Psychological Therapies) for moderate to severe mental health issues or for people who are on waiting lists to access NHS mental health services. By intervening at an early stage, the intervention seeks to prevent the escalation of mental health problems, improve outcome measure scores, and reduce long-term health service costs by minimising the necessity for more intensive treatments. This intervention rationale informs the choice of a comparison group in the CUA study, with the study team comparing SSH to an external group of 120 individuals on a waiting list to access to SilverCloud, a virtual CBT intervention which is designed for patients with similar needs.

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[3] https://www.haveringmind.org.uk/services/supported-self-help/

In the short term, the SSH intervention provides additional engagement between a trained practitioner and clients[4] with mild to moderate mental health problems, with the intention to understand clients' needs and share materials to support them. This is expected to enhance clients' health literacy, understanding of tools and strategies to manage their mental health, improve their wellbeing (for example: improvements in depression, anxiety, overall wellbeing, and general health). This in turn is anticipated to result in reduced contact with healthcare services such as A&E visits and GP attendance. Through improvements in wellbeing, it is also expected clients will have a positive net societal benefit through productive employment and other paid and unpaid contributions.

A theory of change was developed for SSH as part of initial exploration for the study. This captures all inputs, planned activities and outputs, and anticipated outcomes of the programme. It was established at the beginning of the evaluation in August 2023 and represented the study team's understanding of the programme at that time. This is set out in **Annex 1**.

Programme delivery for the local Minds in Wales began in October 2022 and concluded in March 2024. In England the programme ran from October 2023 until March 2025. However, the implementation of the digital system Limbic arrived in August 2023 and it was only from this point in time that local Minds were able to log referrals and digital records were collected for clients. Consequently, data throughout this evaluation refers to the period that digital records are available. This means there are fewer records available for the Welsh Minds due to a smaller overlap in the implementation of IT systems and the end of the programme in Wales. All records are available for clients referred to local Minds in England, as Limbic was already in full operation.

1.2   Introduction to the economic evaluation

In September 2023, Mind commissioned Ipsos and the McPin Foundation to evaluate SSH. Alongside qualitative research carried out by the McPin Foundation, focusing on service user experience and the use of IT systems Mind introduced for the programme (which is covered in a separate, standalone report), Ipsos planned and conducted an economic evaluation.

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[4] individuals who access the service in this report are referred to as clients throughout this report.

In collaboration between the evaluation team and Mind, the agreed evaluation approach sought to answer:

- What is the cost-effectiveness of SSH as an intervention relative to a NHS waitlist control group?

- What are the respective costs and outcomes (consequences) of SSH?

These questions and the results of the evaluation will be of interest to a range of stakeholders, including:

- Potential and current service users.

- Potential commissioners, funders or delivery partners for SSH, such as Primary Care Networks, Integrated Care Boards, NHS providers and corporate partners.

- Policy-makers and senior decision-makers, including national government and NHS officials, and national Mind senior leadership.

- Staff at Mind, ranging from national senior leadership to staff involved in management of delivery of the service.

- Referral partners, including GPs, other healthcare professionals and charity partners.

1.3 Structure and purpose of this report

This report sets out the approach and findings for the economic evaluation of SSH, examining its cost-effectiveness and the wider range of costs and outcomes the programme led to. The remainder of the report is set out as follows:

- Chapter 2 sets out evaluation methods considered for the programme, confirms the study methods selected and their design.

- Chapter 3 sets out the data sources used in the evaluation.

- Chapter 4 presents Cost-Utility Analysis results, including sensitivity analyses.

- Chapter 5 presents Cost-Consequence Analysis findings.

- Chapter 6 discusses the findings, including considerations for future programme delivery and evaluation.

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2 Evaluation Approach

2.1 Selection and review of evaluation methods

The evaluation team explored different options for evaluating SSH in collaboration with Mind. This considered the advantages and disadvantages of using methods which account for and compare the outcomes of the programme to costs in different ways. Discussion of these methods also took into account the context in which SSH was delivered, with roll-out across England and Wales, in real-world care settings, without a Randomised Controlled Trial (RCT) study design. This had implications on how to construct a comparator or control group for the intervention.

The methods considered were:

- **Cost Benefit Analysis (CBA)** which converts all outcomes from the intervention and comparators into monetary terms and offsets these against programme costs to determine an overall net benefit. This can include identifying additional monetary benefit relative to a baseline or counterfactual. This was not considered, as while it brings multiple outcomes together under a single benefit value, it is not recommended or considered as strongly by health decision-makers such as the National Institute for Health and Care Excellence (NICE) in the UK. While CBA is common in some use cases such as public health, it can sometimes be considered contentious to monetise all outcomes in healthcare contexts.

- **Cost-Consequence Analysis (CCA)** which lists all costs and outcomes (called 'consequences' within the analysis) for the intervention without attempting to provide a single summary measure of cost-effectiveness. This approach can be advantageous as it allows the analyst to present details on diverse outcomes, including both changes in NHS service use and clinical improvements. It also offers a fully disaggregated summary of costs and benefits which allows for a richer interpretation by stakeholders and weightings to be applied to areas of interest or priority subject to stakeholders' views or preferences.

  However, on its own, CCA does not produce a single conclusive result, and this renders decision-making more challenging. It is also not straightforward to directly compare disaggregated outcomes and costs from the intervention group to a control group. This is because, in the absence of a RCT or pilot study, it is unlikely other interventions will hold all the same outcomes data in a like-for-like format.

- **Cost-Utility Analysis (CUA)**. This is a specific type of Cost-Effectiveness Analysis (CEA), where the outcome is measured using Quality Adjusted Life Years (QALYs) . The CUA calculates an incremental cost-effectiveness ratio (ICER), which is the ratio of the difference in costs and QALYs between the intervention and its most relevant comparator. This method provides a clear interpretation of relative cost-effectiveness, and can be used to support decision-making across the broader health system, as it aligns with decision-making guidelines[5] outlined by NICE which has adopted a Willingness To Pay (WTP) threshold of £20,000 to £30,000 per QALY for new technologies or interventions in healthcare.

The evaluation team and Mind agreed to take a combined approach, employing both CCA and CUA to apply the strengths of both analyses. The CCA provides an overview of all costs and client outcomes incurred during the programme, while the CUA provides a specific recommendation on whether the intervention is cost-effective relative to a suitable alternative strategy, over a longer time horizon.

2.2   Cost-Utility Analysis study design

CUA compares the relative costs and outcomes (effects) of two or more courses of action. This determines whether an intervention delivers additional health benefits at a reasonable additional cost, thereby contributing to informed decision-making regarding healthcare resource allocation.

In this evaluation, the study team designed the CUA to determine whether SSH results in good value for money for its cost compared to an alternative (set out below).

2.2.1 External control group

The control group (or 'alternative course of action') this study considered in the CUA is one in which individuals do not access services and remain on a NHS waitlist.

In situations where a Randomised Controlled Trial (RCT) is not feasible or available, it is still possible to examine the evidence about the effectiveness and cost-effectiveness of a treatment or approach by identifying a suitable external control group.

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[5] Introduction to health technology evaluation | NICE health technology evaluations: the manual | Guidance | NICE

Comparing the intervention and an external control group involves checking the demographic characteristics of the patient population (e.g., age, gender, ethnicity). If the characteristics in the intervention and external control group are similar, outcomes from this control group are then assumed to be consistent with what would have been observed had there been an internal control group recruited for this study.

A study by Richards et al[6], who carried out a RCT of SilverCloud, an online CBT service, included a control group of 120 individuals assigned to a NHS waiting list for eight weeks before receiving the SilverCloud intervention. In this study, outcomes for these 120 individuals were logged after eight weeks, providing a before- and after- comparison of their time on the waiting list.

The study team used data on this control group from the Richards et al study and assessed whether it was a suitable comparator. This provided a means of generating evidence when RCTs are not possible, due to practical constraints. Alongside this, modelling techniques are necessary under this circumstance, to gather and structure data on costs and outcomes across both groups[7,8].

The external control group constructed from Richards et al functions in the same way as an NHS waiting list control group and so the CUA compares costs and client outcomes for SSH relative to the costs and outcomes for individuals on an NHS waiting list. Tests were conducted on the profile of individuals in the Richards et al control group to ensure this was a suitable and comparable control group (see section 3.2).

This control group is also consistent with the goals of SSH as a programme, which seeks to provide additional access to support individuals with mild- to moderate- mental health problems.

2.2.2 Modelling approach

To compare the SSH intervention and NHS waitlist group, a bespoke decision tree model was developed setting out key parameters that are considered to influence overall cost-effectiveness.

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[6] Richards, D., Enrique, A., Eilert, N., Franklin, M., Richardson, C. R., Timulak, L., & Doherty, G. (2020). A pragmatic randomized waitlist-controlled effectiveness and cost-effectiveness trial of digital interventions for depression and anxiety. NPJ Digital Medicine, 3, 91. **https://doi.org/10.1038/s41746-020-0293-8**. Further details on the Richards et al study are presented set out in an **annex** of this report, along with a weblink to the 2020 study and its supplementary materials.

[7] Buxton, M. J., Drummond, M. F., van Hout, B. A., Prince, R. L., Sheldon, T. A., Szucs, T., & Vra, M. (1997). Modelling in economic evaluation: an unavoidable fact of life. Health Economics, 6(3), 217-227.

[8] Rudmik, L., & Drummond, M. (2013). Health Economic Evaluation: Important Principles and Methodology. The Laryngoscope, 123(6), 1341-1347.

This includes uptake of SSH as an intervention, which refers to the proportion of those referred to SSH who go on to attend an assessment session.

Within the decision tree, costs and outcomes for SSH are contingent on uptake, and on each client's symptom improvement, defined using the same cut-off as Richards et al. This is described further in Section 3. Alongside this, costs for wider NHS services that clients on SSH and individuals in the NHS control continue to access, such as GP appointments, are included in the model as part of costs for each option.

The analysis covers a 12-month time horizon, with outcome data from SSH collected over the six weeks assumed to persist over one year beyond the duration of SSH itself (six weeks). The 12-month time horizon is a reasonable time period over which benefits are expected to last, and is commonly used for studies which evaluate mental health interventions[9].

The structure of the decision tree (set out in **Figure 2.1**) includes:

- **Initial Node:** The left-hand box in Figure 2.1:. This splits out the individuals with mild to moderate anxiety and depression symptoms into the SSH client group and a control group at the start of the study.

- **Intervention Arm:** In this branch, clients are referred to and choose whether to engage with SSH following referral. This arm includes further branches for whether or not the client chooses to take up SSH , and whether or not the client's symptoms improve above or below a cut-off (explained below in section 3.1 where we introduce key outcome indicators.

  Probabilities are then calculated for the likelihood a client arrives at each of these branches. The probability for *no uptake* in this model is the probability that people refuse the service or do not complete an assessment. The probability that symptoms improve is based on the number of clients reporting low anxiety and depression scores using specific self-reported

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[9] Along with the Richards et al (2020) study which monitors outcomes over a 12-month time horizon, other studies use a 12-month time horizon. For example, Littlewood et al. (2015). *A randomised controlled trial of computerised cognitive behaviour therapy for the treatment of depression in primary care: the Randomised Evaluation of the Effectiveness and Acceptability of Computerised Therapy (REEACT) trial*. Health Technology Assessment, 19(101), viii, xxi-171

indicators introduced in section 3.1. How each probability is calculated is set out in section 3.4.

Control Arm: This branch is the NHS waitlist control group, constructed using data from the control group in Richards et al. In this group, individuals do not receive virtual CBT support for the 12-month timeframe.

▪ **End points:** For all arms and branches, end points capture changes in health status, as measured by the EQ-5D score, as well as associated costs. For the SSH arm, each end point is multiplied by the probability that a client is in that branch (based on whether they take up SSH and whether their symptoms improve) to provide an *expected* cost and outcome.

Expected costs and outcomes for the four SSH end points are added together to calculate an overall cost and outcome for Mind, which accounts for differences in the client profile in terms of uptake and symptom improvement.

Figure 2.1: Structure of decision tree model
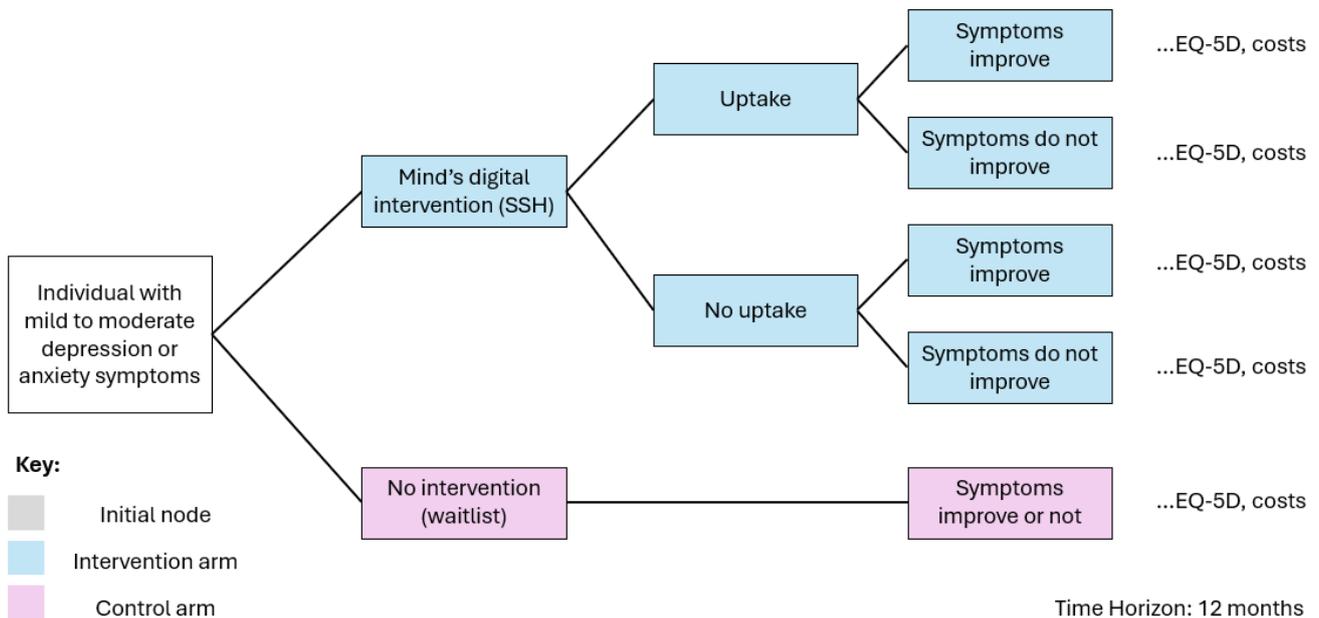
Source: Evaluation team development of model

2.3 Model assumptions

For the purposes of this analysis, the CUA makes the following assumptions. Some assumptions are possible to consider test by altering them (alongside altered other model inputs detailed in **section 3.4**) or running the same model under different conditions.

- **The probability of uptake for SSH is 80%:** Not all individuals referred to SSH proceed to undergo the service, and these individuals are considered under a separate decision tree branch. No uptake is defined as refusal to participate, experiencing eligibility issues or lack of engagement post-offer. The model assumes that 8 in 10 people referred to SSH go on to attend at least one session (80% uptake). We felt it was also important to test whether SSH was still considered cost-effective if, for example uptake was 5% (which assumes 1 in 20 people referred attend at least one session) or when uptake is 100% (which assumes everyone referred attends at least one session). By considering these alternate situations, we were able to determine to what extent, if any, the overall cost-effectiveness of SSH was impacted.

- **People who are referred to the SSH intervention but do not participate in a session also do not use additional health services during the 12-month time horizon:** this assumes that individuals who do not take up this intervention also refuse or do not access other alternative services. Given the potential impact of this assumption, a scenario analysis in which these individuals *do* go on to use other resources is also presented (**section 4.6**) to ensure that the conclusions of the CUA remain consistent.

Additionally, some structural assumptions are made to ensure that results calculated from the decision tree can be easily interpreted. These assumptions are built into the CUA approach the study team has chosen and cannot be altered. There are:

- **The treatment effect remains for the duration of the time horizon:** This assumes that outcomes collected at the end of session 5 of SSH will remain unchanged for the full 12 months. This assumption allows straightforward comparison between the intervention and control groups, simplifies the model by assuming consistent effects, and makes it easier to compare results across different scenarios.

- **The treatment effect represents the average treatment effect for the population:** This follows the same design as an intention to treat (ITT) analysis which is commonly used in Randomised Controlled Trials. This is where all clients who did take up SSH are considered even if they discontinued the service at an earlier support session, thereby capturing the average effect in a real-world setting. This assumption is conservative as it ensures model results reflect the practical application of the intervention without overestimating its efficacy due to dropouts or non-compliance.

▪ **Individuals are not at increased risk of mortality for the duration of the model:** It is assumed for a population with mild to moderate anxiety or depression that clients are not at an elevated risk of mortality within the 12-month timeframe. The model then assumes all individuals remain alive for the duration of the time horizon, and QALYs are estimated using the mean EQ-5D scores without any additional adjustments made for life years.

2.4 Calculation of health and societal benefits

Healthcare interventions commonly generate a wider set of benefits beyond health improvements for patients. In 2015, the Department of Health and Social Care set out a framework for estimating the Wider Societal Impacts (WSI). This framework and resulting calculator were later updated and made publicly available by Premji and Griffin (2024)[10]. The WSI framework considers how improvements in health alter an individual's net contribution to society — the difference between the societal resources they produce versus those they consume.

The framework considers the following aspects of production:

– **Paid production:** The value of labour provided by the individual through paid employment.
– **General unpaid production:** The active work individuals do that benefits others but for which they are unpaid (e.g. domestic work, volunteering).
– **Unpaid sickness care production:** The value of time individuals spend in caring for a friend or relative who is unwell.
– **Unpaid childcare production:** The amount of time spent caring for a child.

Alongside this, the WSI considers the following aspects of consumption:

– **Formally provided residential care:** Paid for privately or publicly.
– **Unpaid care:** required by individuals due to ill health and provided by family or friends.
– **Private paid consumption:** The use of goods and services that are paid for privately, such as housing, clothing, transport, food, communications, and entertainment.
– **Private unpaid consumption:** The use of all the elements of general unpaid production (e.g., domestic work, personal care) that individuals perform for themselves.
– **Childcare consumption:** The use of private paid childcare.

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[10] Premji, S., & Griffin, S. (2024). Assessing the health and welfare benefits of interventions using the Wider Societal Impacts framework. *Value in Health*. Advance online publication. https://doi.org/10.1016/j.jval.2024.07.014

- **Government services consumption:** Services provided directly by the government, such as healthcare and education.

In this evaluation, patient age, sex, mean EQ-5D scores and International Classification of Diseases (ICD) disease chapters were entered into the WSI framework calculator, which estimated sex-adjusted production and consumption amounts for SSH and the NHS waitlist control group. This estimated sex-adjusted production and consumption amounts for SSH and the control group using evidence set out in Premji and Griffin, which indicates the relationship between these inputs and the different areas of production and consumption.

2.5   Cost-Consequence Analysis study design

Cost-Consequence Analysis (CCA) is a form of economic evaluation where disaggregated costs (i.e., the cost of implementing a programme or intervention) are compared with a range of outcomes (consequences), such as health outcomes, quality of life, wellbeing, or cost savings. CCA is often recommended for complex interventions that have multiple effects. Given the impact the SSH is expected to have on multiple measures of mental and physical wellbeing, a CCA is appropriate. It also offers a fully disaggregated summary of costs and consequences which allows for interpretations by stakeholders, allowing weightings to be applied to areas of interest or priority. The data which informs costs and outcomes in the CCA is set out in **section 3.**

CCA does not attempt to summarise costs and consequences in a single measure (such as cost per QALY or Benefit Cost Ratio (BCR)) or in monetary terms, as is the case in CBAs or CUAs. Instead, outcomes are shown in their natural units, and it is for decision makers to determine which elements of the programme they wish to focus on and draw their own conclusions on the programme's effectiveness.

The CCA also serves as a framework to answer to the following questions:

- What cost components make up the programme? How much and what share do these consist of individually?

- What is the total cost of the programme to date?

- What proportion of the programme are setup costs compared with ongoing delivery costs?

- How do the programme costs break down to a cost per client?

- What are the disaggregated outcomes of the programme, compared with pre-intervention?

- Taking the size of the costs and consequences as they are, what would the average programme cost be to still achieve an incremental improvement in each outcome?

3 Data Sources

3.1 Data sources and key outcome measures

Data collected from the Limbic and Views systems[11] were used to provide client data to evaluate SSH. Using both systems, it is possible, first, to identify pre-intervention health and wellbeing scores where an individual has completed clinical surveys. Scores were digitally captured at referral in Limbic, or at the assessment session via a practitioner who is logged into Views at the pre-intervention stage. Where outcomes were recorded at both the referral and assessment stage, the study team used the results from the assessment as a pre-intervention score. Otherwise, the team used whichever score was available.

During the intervention, practitioners then log data at sessions 3 and 5 in Views, if individuals attended these sessions. Practitioners also collect further data (such as service use questionnaires) at other sessions where clients chose not to continue and also logged them in Views.

10,912 clients who registered for the service had their data recorded digitally[12] and their anonymised records were made available to Ipsos. This includes information on their demographics. When looking at outcomes in this report, there is an increasingly smaller sample providing outcomes data at assessments, session 3 and session 5 respectively as individuals progress through or leave the service. Clients can access up to five sessions with a practitioner, plus a further sixth signposting session, tailored to their individual needs should they wish to attend it. Therefore, not all clients will complete all the sessions. Detailed sample sizes are mentioned in **section 5.3**. Key measures were collected at pre-intervention, session 3 and session 5 using the systems set out in **Table 3.1.**

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[11] IT platforms that have been used to log scores for the mental and physical health and wellbeing scores, alongside service use, by practitioners at the referral and assessment stage, alongside sessions 3 and 5.

[12] This figure is relevant only to the number of clients on the digital platforms (Limbic, Views) for which Ipsos was provided data. This figure may be larger in reality when including individuals that registered before the digital platform was implemented, but this data is not available.

Table 3.1: Outcomes data collection platforms and intervals at which data was collected

	Referral	Assessment	Session 3	Session 5
Limbic	GAD-7, PHQ-9			
Views		GAD-7, PHQ-9, SWEMWBS, EQ-5D-5L, Service Use	GAD-7, PHQ-9, SWEMWBS, EQ-5D-5L	GAD-7, PHQ-9, SWEMWBS, EQ-5D-5L, Service Use

Source: Ipsos review of data sources

In further detail, these indicators are:

- Patient Health Questionnaire-9 (**PHQ-9**)[13]: a self-administered scale that measures the severity of depression that is a cut-off for symptom improvement in the decision tree in the CUA and assessed as one of the outcomes in the CCA. It assesses the frequency of depressive symptoms based on nine criteria aligned with the DSM-IV, providing a total score that helps determine the depression level of the individual.

- Generalised Anxiety Disorder-7 (**GAD-7**)[14]: a self-administered scale used to identify the severity of anxiety symptoms that is a cut-off for symptom improvement in the decision tree in the CUA and assessed as one of the outcomes in the CCA. It comprises seven questions targeting core symptoms of anxiety that are then aggregated into a total score, allowing for the evaluation of an individual's propensity towards generalised anxiety disorder.

- The Short Warwick-Edinburgh Mental Wellbeing Scale (**SWEMWBS**)[15]: measures mental well-being through seven positively worded statements that is assessed as one of the outcomes in the CCA. Participants rate how often they have experienced each aspect of well-being over the previous two weeks, resulting in a single score that reflects overall mental health.

- The EuroQol-5D, 5-Level version (**EQ-5D-5L**)[16]: a standardised measure assessing health-related quality of life and is used to capture the *primary* outcome in the CUA (as it allows for the calculation of QALYs) and is also assessed as an outcome in the CCA. It captures five

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[13] Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001 Sep;16(9):606-13.

[14] Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-97.

[15] Further details on SWEBWEBS are available at https://warwick.ac.uk/services/innovations/ and https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/research/validation

[16] Further details are available at https://euroqol.org/

dimensions of health: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression, each with five levels of severity, to provide a comprehensive view of an individual's health status that are then indexed to provide a total score.

The EQ-5D instrument exists in two different forms. The EQ-5D-5L collects outcomes of five dimensions (mobility, self-care, usual activities, pain or discomfort, and anxiety or depression) at five levels[17]. The EQ-5D-3L collects outcomes for the same five dimensions at three levels[18]. EQ-5D-5L was collected for SSH.

While NICE does not currently recommend using the EQ-5D-5L value set for England, but rather the EQ-5D-3L value set, EQ-5D-5L was kept as the measure for this study for comparability purposes to the external control group, which also used the EQ-5D-5L measure. Mapping of EQ-5D-5L to EQ-5D-3L would have required the study team to have access to individual level data for both SSH and the Richards et al control group, with the latter being unavailable.

▪ Data on the frequency of **healthcare service use** is also collected at assessment and the final session clients attend. This asks clients how many services they accessed over the last three months at the last session they attended. Services considered were all reported by practitioners through Views and include clients visiting:

− the GP for either mental health or other purposes;

− hospital outpatient appointments for either their mental health or other purposes; and

− NHS Talking Therapies, or formerly IAPT.

Data on all outcomes have been collected by practitioners across 46 local Minds from August 2023 – March 2025. This data was provided on a monthly basis to Ipsos by Mind.

Table 3.2 summarises details on each outcomes measure collected. For these measures, each individual had up to three different data collection points that were logged for those sessions they chose to attend. At referral or the assessment session (pre-intervention), and then at session 3 and session 5 if these sessions were attended.

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[17] The five levels under EQ-5D-5L are: no problems, slight problems, moderate problems, severe problems and unable to do.
[18] The three levels under EQ-5D-3L are: no problems, some problems, unable to do.

Table 3.2: Summary of physical and mental health and wellbeing measures

	GAD-7	PHQ-9	EQ-5D-5L	SWEMWBS
Full name	Generalised Anxiety Disorder	Patient Health Questionnaire	EuroQol – 5 Dimensions – 5 Levels	Short Warwick-Edinburgh Mental Wellbeing Scale
The scale measures	Anxiety	Depression	Mobility, Self-Care, Usual Activities, Pain/Discomfort, Anxiety/Depression	Mental Wellbeing
Scoring	0–4: minimal anxiety 5–9: mild anxiety 10–14: moderate anxiety 15–21: severe anxiety	0–4: No depression 5-9: Mild depression 10-14: Moderate depression 15-19: Moderately severe depression 20-27: Severe depression	-0.59 –0: a health state that is worse than being dead 0: the worst health you could imagine 1: the best health you could imagine	Scores range from 7 to 35 and higher scores indicate higher positive mental wellbeing

Source: Ipsos review of data sources

3.2 Preparation of outcomes data for CUA

To undertake the CUA, the checks outlined below were undertaken to ensure client outcomes data were suitable for use. These are necessary to avoid introducing biases into the analysis, which may lead to the analysis over- or under-estimating the reported clinical benefits for clients, due to a systematic error.

3.2.1 Testing sample comparability

By confirming that each group has a similar profile of clients in terms of age, gender and their initial health status, it is possible to infer that differences in outcomes across SSH and the NHS waitlist control group are driven by the intervention itself rather than any pre-existing sample differences. To do this, the study team tested whether clients for SSH and the NHS waitlist control

group are comparable in terms of the common characteristics that were available for both SSH and the external control group. This includes their median age, sex, ethnicity and average pre-intervention depression and anxiety scores.

Chi-squared and t-tests were run to compare each group[19]. The chi-squared test assesses if the SSH and NHS waitlist control groups are different in terms of the spread of categorical values like reported sex or ethnicity in each group. The t-test assesses whether there is a statistically meaningful difference in average values in each group for the median age, and average PHQ-9 and GAD-7 scores reported at referral or assessment. For each test, a p-value lower than 0.05 indicates that the demographics for the SSH and waitlist group are different from one another with statistical significance.

The tests revealed that age was the only demographic characteristic which differed significantly across each group, with a median client age of 40 for SSH compared to a median age of 31 in the waitlist group. There was no statistically significant difference in other demographic characteristics, or in baseline PHQ-9 and GAD-7 scores. In discussions with Mind, it was agreed differences in the median age between SSH and the NHS waitlist control group are not likely to result in different impacts in symptom improvement for PHQ-9 and GAD-7 across the groups by the final data collection point. In other words, we do not expect that older individuals, relative to younger individuals, would be more likely to improve in their symptoms through treatment, or vice versa.

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[19] Both tests are commonly used for a variety of statistical applications. For further guidance, see chapters 7 and 8 at https://www.bmj.com/about-bmj/resources-readers/publications/statistics-square-one

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Table 3.3: Result of sample equivalence test

	Mind SSH (N=10,912)	Waitlist (N =120)	p-value
Age, Median (IQR)	39.8 (20)	31 (18)	**<0.0001**
Female sex, N (%)	7,580 (69.5%)	85 (70.8%)	0.7583
White ethnicity, N (%)	9213 (84.7%)	98 (81.7%)	0.3644
PHQ-9 Pre-Intervention, Mean (SD)	13.5 (7.4)	14.2 (5.1)	0.3016
GAD-7 Pre-Intervention, Mean (SD)	12.3 (6)	12.5 (4.2)	0.7159

Source: Analysis of Views data (Mind), Richards et al, 2020 (waitlist)

3.2.2 Addressing missing data

Missing data is a frequent occurrence in health services research due to factors like non-response or client dropout. This is common in studies where clients must complete follow-up questionnaires. Missingness is often associated with specific client characteristics. Where this is the case, it means there may be a systematic / underlying reason for the missingness; in such cases, not addressing this issue will introduce bias to the analysis. Methods and good practice for handling missing data are set out in academic guidance such as Faria et al (2014) [20].

As noted elsewhere, not all clients accessed the full five sessions; there were also potential refusals to complete the questionnaires. This means the total number of missing values is greater than those which are non-missing. Of a total 10,912 clients, some 70-90% of data is missing across GAD-7, PHQ-9, and EQ-5D-5L. Table 3.4: sets out the number of missing and non-missing data points for these outcomes across clients by session 5.As the CUA reports on EQ-5D-5L, PHQ-9 and GAD-7 at session 5, and this is also the data collection point with the highest number of missing data points (given that clients may choose to leave SSH earlier in the programme), it is important to report on and account for missingness up to this stage.

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[20] Faria R, Gomes M, Epstein D, White IR. A Guide to Handling Missing Data in Cost-Utility Analysis Conducted Within Randomised Controlled Trials. PharmacoEconomics. 2014 Dec;32(12):1157–70.

Table 3.4: Outcomes at session 5 which are missing across the 10,912 SSH clients with digital records

	Missing	Non-Missing
GAD-7	7,281	3,631
PHQ-9	7,289	3,623
EQ-5D-5L	9,129	1,783

Source: Analysis of Views data

The primary risk with using the remaining non-missing data without adjustment is that clients that fit a particular profile may have been completing data at session 5 more than others, which introduces a bias. Any analysis using the completed data would then only represent those clients who provided the data, and conclusions would not be generalisable across all SSH clients.

The study team undertook tests to confirm whether missingness in GAD-7, PHQ-9 and EQ-5D-5L scores were associated with client age, gender and ethnicity among clients. For each of the three indicators, a "missing" and "non-missing" group of clients was created. For the two groups, the median age, total number of clients registered under each gender (including Female, Genderfluid, Male, Non-binary, Not given, Prefer not to say and Unknown) and the total number of clients registered under each ethnicity (53 categories in total including prefer not to say and unknown) were calculated. To test whether missing and non-missing data in each outcome were associated with client demographics, the team then applied t-tests for continuous variables (e.g. age), and a chi-squared test for categorical variables (e.g. gender and ethnicity). Each test compared whether the missing and non-missing groups had statistically significantly different profiles in terms of demographics. The results of these tests are in Table 3.5: and demonstrate that the missing and non-missing groups had statistically significantly different demographic profiles.

Table 3.5: Test results – association between missingness and demographics (p<0.05 means missingness is associated with the demographic)

	Age	Gender	Ethnicity
GAD-7	0.000	0.003	0.000
PHQ-9	0.000	0.003	0.000
EQ-5D-5L	0.000	0.026	0.000

Source: Analysis of Views data

From this table, the study team concluded there is systematic missingness in the data. This suggests that without adjustments, the analysis would lead to biased conclusions regarding cost-

effectiveness. To resolve this, an analytical technique called *imputation* provides a methodological means to fill in missing data points, thereby allowing for a more balanced and representative sample. Multiple imputation is a form of imputation that is considered statistically rigorous compared to other forms of imputation[21].

The evaluation team used Predictive Mean Matching (PMM)[22] to impute the session 5 PHQ-9, GAD-7 and EQ-5D-5L total scores for clients. This multiple imputation technique applied a regression model approach to estimate 20 potential values of the outcome variable. The regression model estimated the outcomes expected for each client for whom data was missing, by taking into consideration their age, gender (female, male, other), ethnicity (white, non-white) and financial situation. The final analysis combined the 20 estimates into a pooled estimate using Rubin's rules[23]. Through using PMM, the integrity and statistical properties of the original dataset were retained, offering a more accurate and reliable basis for further analysis of the SSH programme's outcomes.

3.3   Costs data

3.3.1 Programme costs collected for both the CUA and CCA

In total, the study team collected data on a range of set-up costs such as recruitment activities and equipment (i.e. costs that will no longer apply in future if more care is delivered) and delivery costs such as staffing and rent (i.e. costs that will apply in future if more care is delivered).

Data on the costs of the programme has been collected from a variety of sources (**Table 3.6**) including:

- A Qualtrics cost survey (covering salaries in 2024/25) for those local Minds which were actively running SSH at the time of the survey in Autumn 2024[24]. Consequently, data in this survey is based on English local Minds.

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[21] Faria et al (2014). A Guide to Handling Missing Data in Cost-Utility Analysis Conducted Within Randomised Controlled Trials. PharmacoEconomics, 32, 1157–1170.

[22] Newgard and Haukoos. Advanced Statistics: Missing Data in Clinical Research - Part 1 An Introduction and Conceptual Framework. Acad Emerg Med. 2007 Jul;14(7):662-8.

[23] Newgard CD, Haukoos JS. Advanced Statistics: Missing Data in Clinical Research—Part 2: Multiple Imputation. Academic Emergency Medicine. 2007 Jul;14(7):669–78.

[24] Not all English Minds responded to the survey, and not all responded comprehensively. Assumptions for the overall programme have been made and applied using the data provided from those who responded. For instance, that the average salary across all Minds is equal to the average salary across those Minds which responded to the survey, which includes a range of Minds spread across England.

- Flexigrant data (covering staff FTE and hours as well as expenditure for the second half (H2) of the 2023/24 financial year).

- Set-up and licensing costs for Views and Limbic.

- Information provided by Mind on its training programme, including the frequency and duration of training and salaries of training providers (Mind staff)

- Additional costs from literature including rental costs.

Table 3.6: Data sources

Labour		Estate Use		Other (IT, training, recruitment, materials)	
Source	Use	Source	Use	Source	Use
Flexigrant report for H2 2023-24	Staff FTE, Hours, per cent of time spent on direct client contact	Survey to Minds in Q3 2024-25	Room booking and utilisation	Flexigrant report for H2 2023-24	Additional expenditure lines
Survey to Minds in Q3 2024-25	Identify labour bands and salaries	Public and third-sector rental comparators	Rates for room use	Central Mind team	IT platform costs, central training costs

Source: Ipsos review of data sources

Where data only covers a certain time period (for example, Flexigrant sets out staff hours and expenditure for half a year over H2 2023-24) they will be pro-rated to represent the lifetime of the programme.

The way in which the evaluation methods consider costs differ. The CUA includes incremental costs to draw relative comparisons with the NHS waitlist control group, whereas the CCA looks at the total cost of SSH including all set-up and delivery costs. To be consistent with costs collected and accounted for in Richards et al, the CUA considers the same intervention costs as that study. However, we also run a version of the CUA using *all* variable costs identified for the programme, so check the findings of the analysis remain consistent. Costs considered under each method are set out in Table 3.7:.

Table 3.7: Costs included in CUA and CCA

Cost Measure	CUA – Incremental costs in Richards et al	CUA -all variable costs	CCA
Labour	✓[1]	✓[2]	✓[2]
Materials	X	✓	✓
Recruitment costs	X	X	✓
Capital	X	X	✓
Central training	✓[3]	✓[3]	✓[3]
Local Mind training	X[3]	✓[3]	✓[3]
IT system set-up	X	X	✓
IT system licenses	✓	✓	✓
Initial assessment	✓	✓	X
Programme sessions	✓	✓	X
Service use	✓[4]	✓[4]	X[4]

Source: Ipsos review of data sources
Notes: 1. Staff costs in the CUA (incremental costs) focus on delivery of the initial assessment and programme sessions, as well as staff management, including oncosts 2. Staff costs in the CUA (all variable costs) and CCA total up all staff expenditure including downtime or admin time, and also include oncosts. 3. The training for SSH is understood to be centrally delivered and this enables recruits to take on the practitioner role. However, in the CUA (all variable costs) and CCA, an extra expenditure line is included as local Minds list their own training activities in Flexigrant. This is included in the CCA to capture full programme cost but is not understood to be part of the official programme training carried out. 4. In the CUA wider service use is modelled as a cost alongside the cost of delivering SSH. In the CCA, savings from service use are included but as an outcome.

3.3.2 Programme costs and wider healthcare service use costs used in the CUA

The CUA includes three groupings of incremental costs, to draw relative comparisons with the NHS waitlist control group in line with the Richards et al. study. These are (1) the direct cost of delivering SSH per client, (2) the average cost from clients attending wider NHS services while also participating in SSH, and (3) the average cost for individuals on NHS waitlist attending NHS services.

(1) and (2) added together are the costs calculated for the intervention arm in the decision tree for the branches where individuals uptake SSH, and (3) is the cost for the control arm in the decision tree.

The calculation for costs is set out below in **section 3.4.3**.

3.4   CUA model parameters

Model parameters are the numerical amounts in the decision tree which represent costs, the probability that a client follows a certain branch in the decision tree, and utility scores (QALYs) reported clients. Each parameter is calculated from data Mind has provided, using Richards et al. (for the external control group) or using assumptions stated above (such as intervention uptake).

3.4.1 Probabilities for clients referred to SSH

As set out in **section 2.2** the decision tree model assumes that clients referred to SSH (in the intervention arm) choose whether to engage with SSH and attend an assessment session following referral. This is also referred to as uptake.

The decision tree's intervention arm also includes further branches with probabilities for whether the client's symptoms improve. PHQ-9 and GAD-7 scores at session 5 are used as cut-offs to determine whether client symptoms improved for depression and anxiety respective. Client symptoms are considered improved if their PHQ score is below 10, or their GAD-7 score is below 8. These cut-offs are also used in the Richards et al. study to assess improvements in symptoms.

The costs and outcomes at the end of each branch (uptake / no uptake and symptoms improve / symptoms do not improve) in the decision tree differ. For example, as outlined in **section 2.3** a person who does not take up SSH as in intervention is also assumed not to use alternative NHS services in the default version of the model. This means these clients are less likely to see an improvement in their quality of life, but also do not require the same delivery cost or incur wider service use costs. As their costs and outcomes differ, it is important that the probability of uptake and probability of symptom improvement is considered carefully.

The probability for clients reporting an improvement in depression is estimated by taking the total number of clients at session 5 reporting a score of below 10 for PHQ-9, and dividing this by a total number of clients who attended session 5. The probability for clients who take up SSH reporting an improvement in anxiety is estimated by taking the total number of clients at session 5 reporting a score of below 8 for GAD-7, and dividing this by a total number of clients who attended session 5.

The definition for no uptake in this model discussed with Mind in Autumn 2024, covers people who refuse the service or do not complete the assessment. It is set to 80% as an assumption in the model.

Table Table 3.8: below sets out the model probabilities.

Table 3.8: Model probabilities

	Model input	Source
Probability of uptake	80%	Assumption
Probability symptoms improve for those with Depression who uptake intervention (PHQ-9 score <10)	82%	SSH programme data – Per cent of clients by session 5 reporting PHQ-9 score below 10.
Probability symptoms improve for those with Depression who do not uptake intervention (PHQ-9 score <10)	17%	Richards et al.
Probability symptoms improve for those with Anxiety who uptake intervention (GAD-7 score <8)	78%	SSH programme data – Per cent of clients by session 5 reporting GAD-7 score below 10.
Probability symptoms improve for those with Anxiety who do not uptake intervention (GAD-7 score <8)	17%	Richards et al.

Source: Cost-Utility Analysis decision tree model

3.4.2 EQ-5D-5L scores

Using the same cut-offs above for whether clients attended an appointment or saw an improvement in PHQ-9 or GAD-7 by session 5, the average EQ-5D-5L scores per group are calculated. These average amounts include imputed client data, which as explained in section 3.2, removes bias from the analysis due to under-reporting among some demographic groups.

These can be directly interpreted as the average QALY a client experiences over the 12-month time horizon for the study. This is a normal scale where a score of one is a year in perfect health and is the ceiling for what clients can report. The average EQ-5D-5L score for individuals on the NHS waitlist was taken from the Richards et al. study, however it was a much lower score and there is a risk it is not directly comparable. To be conservative, the same utility "for those with Depression whose symptoms do not improve" is used for "those who remain on the waitlist". **Table 3.9** sets out the EQ-5D-5L scores used in the model.

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Table 3.9: Model EQ-5D-5L scores for each branch

	Model Input	Source
Mean utility for those with Depression whose symptoms improve	0.92	EQ-5D-5L scores for SSH clients
Mean utility for those with Depression whose symptoms do not improve	0.85	EQ-5D-5L scores for SSH clients
Mean utility for those with Anxiety whose symptoms improve	0.92	EQ-5D-5L scores for SSH clients
Mean utility for those with Anxiety whose symptoms do not improve	0.86	EQ-5D-5L scores for SSH clients
Mean utility for those who remain on waitlist	0.85	EQ-5D-5L scores for SSH clients

Source: Cost-utility analysis decision Tree model

3.4.3 Costs for the CUA

As set out in section 3.3.1, there are three groups of costs considered in the analysis. These are (1) the direct cost of delivering SSH per client, (2) the average cost from clients attending wider NHS services while also participating in SSH, and (3) the average cost for individuals on NHS waitlist attending NHS services.

In the initial version of the CUA, the following calculations are made to determine costs.

(1) Costs for delivering SSH

When using the same cost categories considered in Richards et al, the direct cost per participant associated with SSH itself, is calculated as a mean of just over **£107**. This consists of four cost components which are presented in **Table 3.10.**

1 Maintaining and operating the Views and Limbic digital platforms, which totals **£334,603** (£300,000 for Limbic and £34,603 for Views). This is a cost per client of **£31** across all 10,912 clients recorded from August 2023 irrespective of their uptake or engagement with SSH. This does not include a separate sunk cost for the set-up of Views.

2 Conducting initial assessments with participants, which totalled **£113,573** at a cost per client of **£12** across 9,528 clients who were recorded to have attended these assessments. The cost of an assessment is calculated using hourly pay rates for practitioners on a mean salary of £31,522 (which includes training costs per practitioner, a 13.8% uplift for employer national insurance contributions and 4% for employer pension contributions). Each assessment is assumed to run for 40 minutes.

3 Conducting each session (sessions one to six) with participants throughout SSH, which totalled **£554,185**. The same salaries as above apply, but each session is assumed to run for

20 minutes. The number of clients who attended session one through to session six drops off due to attrition in the programme. However, as clients only report their outcomes at Sessions 3 and 5, it is only known for certain that 4,672 clients attended session 3 and 3,631 clients attended session 5, therefore showing a steady drop off. For other sessions the study team assumed a linear change in attendance from assessment to session 3, and from session 4 to session 6. Using these calculations, the cost per session is £6, on average clients attend 3.12 sessions, and the average cost per client is **£18**.

4   Supervision and management activities, with a total cost of **£502,003**. Line managers and clinical supervisors are assigned an average national salary of £40,099 and £46,253 based on average salary amounts submitted across local Minds (which includes a 13.8% uplift for employer national insurance contributions and 4% for employer pension contributions). These are converted to an hourly rate and multiplied by total hours logged for managers and supervisors in Flexigrant. As the Flexigrant data we hold covers H2 2023-24, these total costs are then multiplied for the timeframe over which the programme recorded cases from August 2023 to March 2025 (1.7 years). Assuming supervision costs are spread across all clients, the per client cost is **£46**.

Table 3.10: Costs of delivering SSH

Cost	Number of clients	Total cost	Cost per client
1) Platform license costs	10,912	£334,603	£31
2) Assessment costs	9,528	£113,573	£12
3) Review costs	Set as follows for each session, using counts for session 3 and 5 to estimate other session counts Session 1 - 7,909 Session 2 - 6,291 Session 3 - 4,672 Session 4 - 4,152 Session 5 - 3,631 Session 6 - 3,111	£554,185	£19
4) Supervision costs	10,912	£502,003	£46
Total		**£1,504,365**	**£107**

Source: Analysis using Qualtrics and Flexigrant from Mind as well as bespoke conversations with Mind regarding training and IT costs.

To ensure that a variety of additional variable costs not considered under Richards et al, but which are incurred by the SSH programme, are considered it is important to run in a separate version of the CUA including these. This is a conservative approach and helps to test that the CUA still provides consistent results with these costs. Costs under this scenario are derived as follows and are presented in **Table 3.11**.

1 Maintaining and operating the Views and Limbic digital platforms are calculated as before, totalling **£334,603** with is a cost per client of **£31**.

2 Rather than costing initial assessments and sessions with participants, the total staff time for SSH practitioners is costed (which includes their time in appointments). This is costed by taking the average practitioner salary of £31,522 (which includes training costs per practitioner, a 13.8% uplift for employer national insurance contributions and 4% for employer pension contributions) and multiplying it by the 47.8 FTE totalled across Minds which reported the number of practitioners they hired. Adjusting for the timeframe over which the programme recorded cases from August 2023 to March 2025, this led to a total practitioner staff cost of **£2,509,853**, which comes with a per client cost of **£230**.

3 All admin and other staff costs are now included and calculated using the same method as step 2. An average admin staff salary of £27,626 and FTE of 4.41 is used, with no Minds hiring a dedicated admin staff member solely for SSH. Adjusting for the timeframe over which the programme recorded cases from August 2023 to March 2025, this led to a total admin staff cost of **£202,943** which comes with a per client cost of **£19**.

4 All other staff costs are now included and calculated using the same method as step 2. An average other staff salary of £46,643.23 and total FTE of 4.13 is used. Adjusting for the timeframe over which the programme recorded cases from August 2023 to March 2025, this led to a total other staff cost of **£320,885** and per client cost of **£29**.

5 Supervision and management activities are calculated as before, with a total cost of **£502,003** and per client cost of **£46**.

6 Additional local training and materials variable costs were taken from Flexigrant for H2 of 2023/24 and scaled up to cover the timeframe over which the programme recorded cases from August 2023 to March 2025. These training costs amounted to £37,581 and materials costs amounted to £47,137, totalling **£87,418** or **£8** per client.

Table 3.11: Costs of delivering SSH, including all programme variable costs

Cost	Number of clients	Total cost	Cost per client
1) Platform license costs	10,912	£334,603	£31
2) SSH practitioner costs	10,912	£2,509,863	£230
3) All admin staff time	10,912	£202,943	£19
4) All other staff time	10,912	£320,885	£29
5) Supervision costs	10,912	£502,003	£46
6) Local training and materials	10,912	£84,718	£8
Total		**£3,870,297**	**£363**

Source: Analysis using Qualtrics and Flexigrant from Mind as well as bespoke conversations with Mind regarding training and IT costs.

(2) Wider service use for participants participating in SSH

The average cost for providing other NHS services to each SSH client was estimated at **£447.92** per client. This is calculated by taking the responses to service use questionnaires completed by clients over the duration of SSH, which asked for the number of times clients visited GPs, IAPT, Talking Therapies and outpatient services within a three-month period. Each type of healthcare activity was assigned a 2017/18 unit cost[25] from which a total cost was calculated using the mean number of visits. The cost of all activities were summed and adjusted to an annual amount.

As the Richards et al. study used 2017/18 unit costs, costs from the same year are taken here for consistency. However, as SSH was delivered from 2023 to 2025 and the cost of delivering NHS services at this time has increased, it is sensible to inflate prices. The total service use costs 2017/18 (which totalled 366.74) is inflated to 2023/24 prices (which is calculated at £447.92).

The inflation calculation uses an index called the NHS cost inflation index for pay and prices[26]. This index follows changes in costs for NHS services per year and is published annually. It is commonly used in health services research and economic studies. The index for years between 2023/24 and 2017/18 is multiplied by the costs in 2017/18 to represent the effect of inflation and bring historic prices up-to-date.

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[25] Source: Unit Costs of Health and Social Care, PSSRU, University of Kent. https://www.pssru.ac.uk/project-pages/unit-costs/
[26] The NHS Cost Inflation index is set out in the latest 2024 unit costs report published by the Personal Social Services Research Unit (PSSRU) here: https://www.pssru.ac.uk/unitcostsreport/

Wider service use by participants remaining on the NHS waitlist.

The average cost for providing other NHS services to individuals on the NHS waitlist was estimated at **£451.75**. These costs use the same responses to service use questions asked to people in the NHS waitlist control group in the Richards et al. study. The same method to gather 2017/18 unit costs, calculate a total cost in line with the average number of contacts per service, annualise and inflated to 2023/24 amounts is applied...,The costs included in the decision tree model for the intervention arm – costs (1) and (2) – and control arm – cost (3) – are presented below in **Table 3.12**.

Table 3.12: Model costs

	Model Input – using Richards et al. cost groups	Model Input – using all variable costs	Source
(1) Cost of Mind SSH	£107.37	£362.60	SSH programme costs set out in Flexigrant and Qualtrics
(2) Mean costs for those who undertake intervention	£447.92	£447.92	SSH service use questionnaire data inflated using NHS Pay and Prices Index
(3) Mean costs for those who remain on waitlist	£451.75	£451.75	Richards et al. service use questionnaire data inflated using NHS Pay and Prices index

Source: Analysis using Qualtrics, Flexigrant and resource use surveys from Mind and Richards et al.

3.5 CUA model sensitivity analyses

Sensitivity analyses are methods which test model results and recommendations, by varying its parameters from the default figures used in the model (the base case). As part of the CUA, the following types of sensitivity analysis are carried out:

- **One-way sensitivity analysis** which assesses how changes in individual parameters affect the results of the analysis . Each input is decreased one at a time to a lower-limit and increased one at a time to an upper-limit. The changes applied to the model input in either direction are set out in **Table 3.13.** The rationale for selecting lower and upper limits is as follows:

  - For **uptake of SSH**, the study team is assumed to be 80% in the initial model (i.e. 8 in 10 people referred to SSH attend at least one session). Given this is an assumption, it is tested with a lower limit of 5% (i.e. 1 in 20 people referred to SSH attend at least one session) and upper limit of 100%.

– Costs from **wider NHS service use** for individuals who uptake SSH, and the **cost of delivering SSH**, are tested at 25% and 125% of the amount tested in the model. This range reflects the fact that costs tend to skew to the left of (below) the average, where there are likely to be a cluster of costs at the lower end rather than the upper end of a cost distribution. The same approach is taken by altering both the £107 (incremental) and £363 (all variable costs) amounts for delivering SSH depending on costs.

– **Mean utilities (QALY scores)** for people referred to SSH, whose symptoms improve, are tested at the lower limit using the same utility (QALY score) for those whose symptoms do not improve. The upper limit is a much higher utility score (0.98) which is close to near-perfect health. This range covers a high range in possible outcomes for clients and is a conservative approach to testing different model inputs.

– The **probability that symptoms improve** is tested from a much lower probability (from 0.17, where less than 20% of peoples' symptoms improved) to 1.00 (at which every client's symptoms improved). The value 0.17 was derived from the external control group, where it was observed that 17% of those on a waitlist experienced improved symptoms over time, without intervention. We therefore assume this will be the minimum proportion for which individuals in SSH will also experience an improvement in symptoms. The upper limit, on the other hand, assumes all individuals (100%) experience an improvement in symptoms.

▪ **Probabilistic sensitivity analysis** considers the robustness of the cost-effectiveness findings by accounting for uncertainty across multiple model parameters at once, applying a Monte-Carlo simulation approach[27]. Key parameters are sampled from pre-assigned probability distributions, which are informed depending on the type of parameter and available data.

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[27] A further explanation of Probabilistic Sensitivity Analysis and Monte-Carlo Simulation is available at https://yhec.co.uk/glossary/probabilistic-stochastic-sensitivity-analysis/ and https://yhec.co.uk/glossary/monte-carlo-simulation/

Table 3.13: List of model parameters altered in one-way sensitivity analysis, and the lower and upper limits they were altered to.

	Model Input	Changes to Model Input - Lower Limit (LL)	Changes to Model Input - Upper Limit (UL)
Probability of uptake	80%	5%	100%
Mean healthcare resource costs for those who undertake intervention	£447.92	£111.98	£559.90
Cost of SSH	£107.37 / £362.60	£26.84 / £90.65	£134.21 / £453.25
Mean utility for those with Depression whose symptoms improve	0.9212	0.8543	0.9800
Mean utility for those with Anxiety whose symptoms improve	0.9209	0.8543	0.9800
Probability that symptoms improve for those with Depression who uptake intervention	0.82	0.17	1.00
Probability that symptoms improve for those with Anxiety who uptake intervention	0.78	0.17	1.00

Source: Cost-Utility Analysis decision tree model

4 Cost-Utility Analysis Findings

4.1 Cost-Utility Analysis overview

The CUA aims to compare costs and quality of life gains for SSH clients against the NHS waitlist control group of individuals on an NHS waitlist. This evaluation quantifies the costs and effects associated with the SSH intervention relative to the NHS waitlist control group, over a time horizon of 12 months.

The model findings in the 'base case' (the default version of the model which uses the assumptions set out in section 2.3 and parameters set out in section 3.4, using the £109 cost for delivering SSH) suggest that SSH is cheaper and more effective than the NHS waitlist control group over the 12-month period. The ICER is **–£167** which demonstrates that the intervention 'dominates'[28] the alternative of doing nothing. The Net Monetary Benefit (assuming a WTP of £20,000 per QALY gained) is £17,542. These findings are set out in sections 4.2 and 4.3.

Sensitivity and scenario analyses carried out in the model – including scenarios where those who do not uptake SSH also use wider NHS service, and where the programme costs includes all variable costs totalling £363 – suggest that SSH consistently remains cost-effective relative to the waitlist over 12 months. These findings are set out in sections 4.4 - 4.6.

4.2 Cost-Utility Analysis results

Results from the CUA provide a clear measurement of the SSH programme's value of health outcomes relative to costs.

The result is typically expressed as an **ICER** which offers insight into whether the programme delivers health improvements at an economically justifiable cost. It is calculated by dividing the difference in costs and the outcome of focus (in this case health utilities) between the intervention and a comparator. A negative ICER driven by cost savings, as in this context, suggests that the programme is dominant.

Another way of reporting the same results is as a Net Monetary Benefit (NMB) amount for SSH and the NHS waitlist control group. Alongside QALY gains, the NMB is calculated using a WTP threshold, which is typically a financial amount of £20,000 per QALY gained or up to £30,000 per QALY gained in line with NICE guidelines for what constitutes good value for money. The NMB then subtracts costs from the monetised QALY gains. In a CUA study, the option with the highest NMB score represents the best value for money of those considered.

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[28] A dominant treatment option is one that is both less costly and results in better health outcomes than the comparator treatment.

A favourable cost effectiveness result indicates that the SSH intervention provides health improvements at a cost that is within acceptable thresholds, making it a viable option for resource allocation within the healthcare system.

CUA findings demonstrate that the SSH programme is dominant compared to the NHS waitlist control group. The programme delivers health gains while reducing costs. These findings suggest that the SSH intervention represents a valuable allocation of healthcare resources, supporting its potential adoption and maintenance within the NHS framework. Specifically:

- The programme reports a negative ICER **(–£167)**, which in the context of SSH being cost saving suggests it delivers greater health gains than the NHS waitlist control group while being cheaper.

  When WTP is set at £20,000 per QALY gain, SSH has a higher Net Monetary Benefit of £17,542[29] compared to the NHS waitlist control group at £16,634. With WTP set at a £30,000 per QALY gain, SSH has a higher Net Monetary Benefit of £26,535 while the NHS waitlist control group has a Net Monetary Benefit of £25,177. With higher Net Monetary Benefit amounts than the waitlist group, SSH is considered the better value for money option.

The key model results for SSH and the waitlist control, from which the above figures are calculated, are set out in **Table 4.1**. The effects column sets out the mean EQ-5D-5L scores for the SSH and NHS waitlist control groups, which represent the benefits accrued to each arm. The incremental row takes the difference in costs and effects between the SSH and the NHS waitlist control group. The ICER is then calculated as $(\text{Cost}_{SSH} - \text{Cost}_{Control}) / (\text{Effect}_{SSH} - \text{Effect}_{Control})$.

Table 4.1: Deterministic model findings

	Costs (SSH delivery and wider health service)	Effects	ICER	NMB (£20K)	NMB (£30K)
Mind SSH	£444.23	0.8993		£17,542	£26,535
Waitlist	£451.75	0.8543		£16,634	£25,177
Incremental	–£7.52	0.0450	– £167	+£908	+£1,358

Source: Cost-Utility Analysis decision tree model

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[29] Calculated as 0.8993 QALYs over the 12 months, multiplied by the £20,000 Willingness To Pay per QALY, then minus costs at £444.23 = £17,542 net monetary benefit.

4.3   Calculation of wider societal benefits

The above results consider direct benefits to the individuals who have used SSH. Broader inclusion of benefits, including societal contributions and reduction in consumption of shared resources, such as the use of formal or informal care, adds additional societal considerations to the results. These wider benefits are set out in section 2.4.

Where individuals better manage their mental health, they are more likely to experience improved work attendance and performance and improve their workplace productivity. Equally they are less likely to require and consume care services, childcare services or public welfare services. When considering these within the overall wider societal impacts framework, a positive annual net productivity rate of £27,240 is yielded which is **£6,727** higher than the net productivity rate for those in the waitlist control. This further suggests that SSH provides good value for money relative to the waitlist control.

4.4   One-way sensitivity analysis

The CUA results were tested by changing inputs or assumptions which contributed to the analysis. This helps to consider if the results will change by enough to affect the conclusion that SSH is cost-effective relative to a comparison control group. The study team changed assumptions for figures in the analysis one at a time (called one-way sensitivity analysis) the impact of each change on the ICER result was presented as a graph. This is commonly called a Tornado diagram and is, set out overleaf in **Figure 4.1.**

The centre axis of the graph is set to the ICER presented above in Table 4.1:. Therefore, any increase or decrease in model inputs in shown in the graph as the corresponding change in the ICER below or above the amount that was previously calculated. Movements to the left in the graph decrease the ICER (which, in this context, makes SSH cost-effective to a greater degree compared to the NHS waitlist control group). Movements to the right in the graph increase the ICER, however SSH remains cost-effective so long as the ICER result is below the £20,000 to £30,000 cost-effectiveness threshold.

Figure 4.1: One-way sensitivity analysis (Tornado diagram), showing how changes to model parameters in Table 3.13 affect the ICER result (axis starts at -£167)
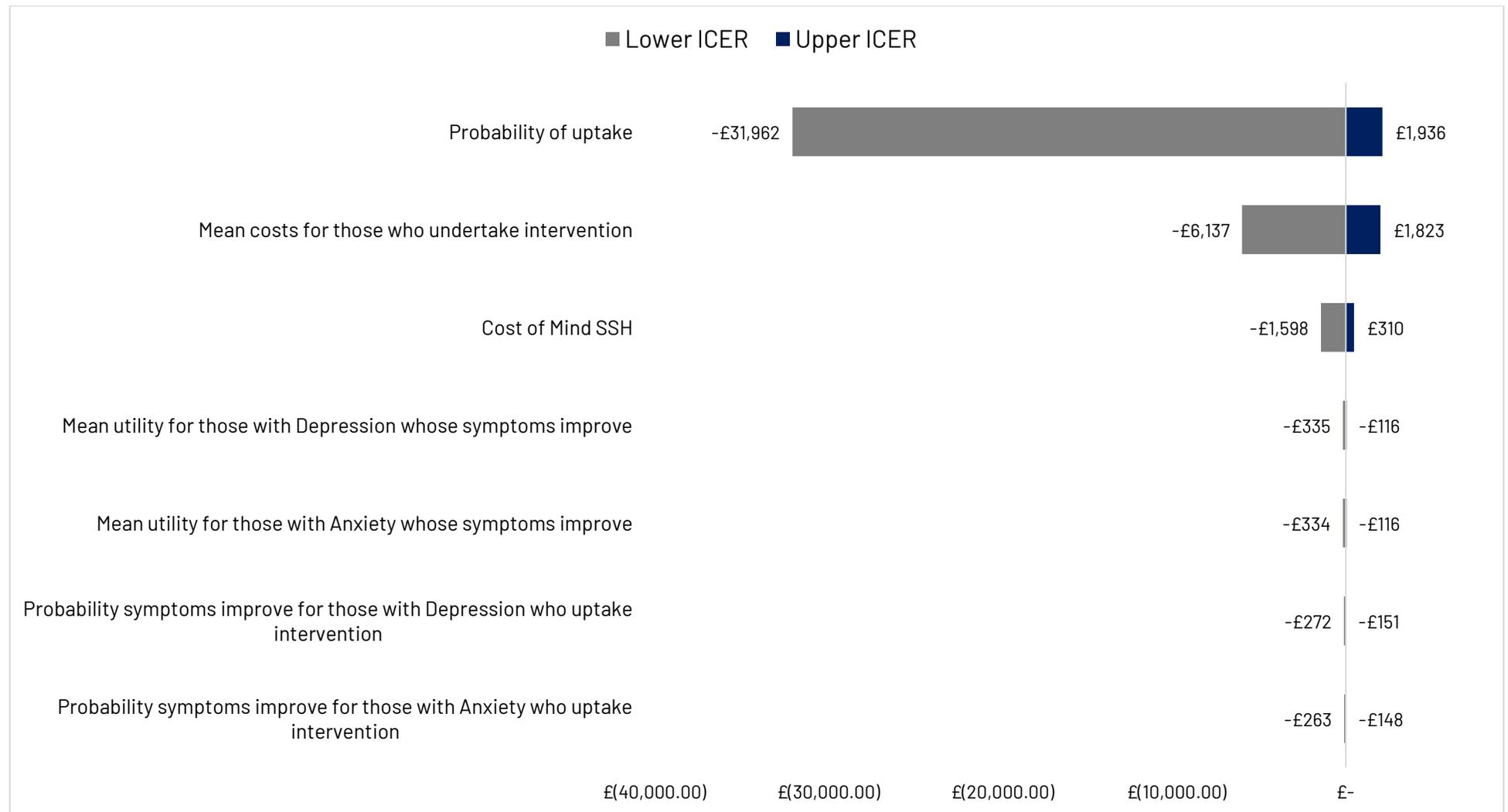
Source: Cost-Utility Analysis decision tree model

This diagram shows that only two model inputs, when changed, lead to large changes in the model ICER. The ICER does not – for any change made – increase to £20,000 per QALY gained. This indicates that SSH is always cost-effective relative to the NHS waitlist control group. For example:

- In the first row in the diagram, when the model is altered to set uptake to 100% (in other words, all clients referred to SSH attend a session) the ICER increases to +£1,936. This indicates that SSH is now more costly than the NHS waitlist control group (when considering both wider NHS service use among clients and the cost for delivering SSH to everyone referred), however SSH is still cost-effective compared to the NHS waitlist control group as the ICER is well below £20,000. This indicates that SSH remains still cost effective relative to the NHS waitlist control group. This is because the higher average QALY gained by clients through SSH is sufficiently large. Reducing the uptake below 80% further reduces the ICER which results in SSH being even more cost-effective relative to the NHS waitlist control group.

- In the second row in the diagram, when the wider NHS service costs for those referred to SSH is increased by 25% from £448 to £560, the ICER increases to +£1,823. This indicates that SSH is now more costly than the NHS waitlist control group, as a higher use of wider NHS services among clients of SSH costs more. However, as above, the ICER is still well below £20,000 and this indicates that SSH is still cost effective relative to the NHS waitlist control group. Reducing the cost of wider NHS services below £448 reduces the ICER which results in SSH being even more cost-effective relative to the NHS waitlist control group.

- In the third row in the diagram, when the cost for delivering SSH is increased by 25%, the ICER increases to +£310. This indicates that SSH is now more costly than the NHS waitlist control group, as a higher use of wider NHS services among clients of SSH costs more. However, as above, the ICER is still well below £20,000 and this indicates that SSH is still cost effective relative to the NHS waitlist control group. Reducing the cost of delivering SSH reduces the ICER further which results in SSH being even more cost-effective relative to the NHS waitlist control group.

- All remaining rows in the diagram either lower the utility (QALY improvement) for clients whose symptoms improve, or lower the probability that symptoms improve for clients of SSH. Each of these reduces the clinical effect of SSH while holding its cost at the same levels. However, in each case as the overall cost for SSH is lower than the NHS waitlist control group, and the effect of remains higher, and so the ICER remains negative. This indicates that SSH is still dominant compared to the NHS waitlist control group as, in this context, it is still less costly and results in clients having a higher QALY than compared to being on the NHS waitlist.

Changes to the probability of uptake leads to the largest shifts in the ICER (the top bar in the diagram). The ICER ranges from -£31,962 to £1,936 for uptake probabilities of 5% and 100% respectively. Altering the uptake amount does not change the final decision to adopt SSH, as the

highest ICER value calculated remains well below £20,000 to £30,000 which is the cost-effectiveness threshold.

4.5 Probabilistic Sensitivity Analysis (PSA)

The probabilistic sensitivity analysis considers the robustness of the cost-effectiveness findings by accounting for uncertainty across multiple model parameters at once, unlike the one-way analysis which can only alter a single parameter at a time while holding others constant. It applies a Monte Carlo simulation approach in which key parameters are sampled from pre-assigned probability distributions over 1,000 iterations. SSH parameters for costs, probabilities of health outcomes, and shape and scale parameters are estimated for each distribution using SSH programme data.

The final outputs from the PSA provide mean costs and QALYs for SSH and the waitlist comparator across all iterations as well as mean ICER and NMB values. If these mean values are close to the deterministic results, this indicates there is stability in the overall model and there is high confidence in the 'base case' model results. An additional value of the PSA is the ability to estimate whether, for each iteration, SSH is considered cost effective relative to the waitlist control, and to evaluate the overall probability that SSH is cost effective for varying WTP thresholds (from £0 to £100,000 per QALY gained). This provides additional confidence in the recommendation to adopt SSH relative to the waitlist control.

The PSA finds that at all WTP amounts, SSH remains the recommended intervention to adopt over the waitlist control, as it has a higher probability of being cost effective. This is set out in **Figure 4.2.** At a threshold of £20,000 per QALY, the probability that Mind's SSH intervention is cost effective is 64.8% and at a threshold of £30,000 per QALY this is 64.2%. The level of these probabilities suggest variability in the model parameters, which is expected and increased in part by the requirement to impute data. However, critically, this analysis does *not* change the overall recommendation to adopt SSH relative to the waitlist control.

Figure 4.2: Cost Effectiveness Acceptability curve – probability that SSH is cost effective relative to the waitlist at different WTP thresholds
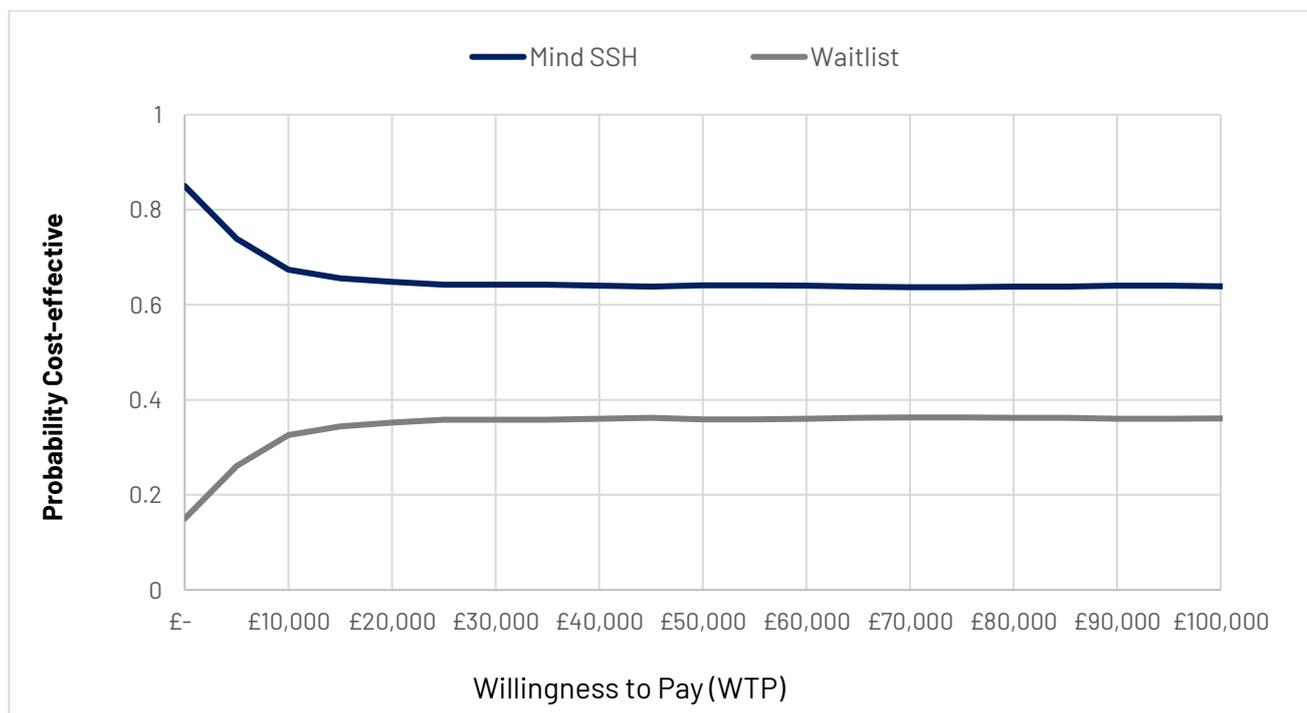
Source: Cost-Utility Analysis

4.6   Scenario analysis with alternative health service use assumptions

The base case model assumed that those clients for SSH who do *not* take up the service also do not consume other healthcare resources. This is based on the assumption that the majority of these clients were likely to have been offered access to SSH and chose not to uptake the intervention, and therefore would not choose to uptake other relevant support. In this scenario analysis, that assumption is tested by assuming clients who do not take up SSH to still incur costs for alternative healthcare resources and varying the size of these additional costs. This scenario continues to use the £109 cost for delivering SSH.

Table 4.2: Table 4.2 presents the model results under this scenario analysis. In this scenario, the cost of SSH is higher relative to the NHS waitlist control by £83, while the average QALY gained by each client of SSH over the 12-month period remains the same. The ICER is positive at £1,843. While this means that SSH does not 'dominate' the waitlist control, the ICER score still lies well below the threshold of £20,00-£30,000 per QALY gained. The NMB for SSH is positive and higher than the waitlist control at each WTP level. Therefore, SSH is still considered cost-effective.

Table 4.2: Deterministic model findings under the scenario analysis

	Costs (SSH delivery and wider health service)	Effects	ICER	NMB (£20K)	NMB (£30K)
Mind SSH	£533.81	0.8993		£17,453	£26,446
Waitlist	£451.75	0.8543		£16,634	£25,177
Incremental	£82.06	0.0450	£1,823	£819	£1,269

Source: Cost-Utility Analysis – results from separate model running alternative scenario

As part of this scenario analysis, one-way sensitivity analysis and PSA were undertaken again. The sensitivity analyses found no change in the recommendation to adopt SSH over the waitlist control.

For instance, under the one-way sensitivity analysis presented in **Figure 4.3**, raising the costs for wider NHS service clients referred to SSH use, to £560, led to the highest ICER result of £4,310. This has a high impact on the model under this scenario, as these wider service costs now apply to both those who take up SSH and those who do not. However, this still is well below the WTP threshold of £20,000-£30,000 per QALY gained. No changes to model inputs result in the ICER increasing up to this threshold.

The PSA continues to find that irrespective of the WTP, SSH remains the recommended strategy to adopt over the waitlist control.

Figure 4.3: One-way sensitivity analysis (Tornado diagram) under the scenario analysis. (Axis starts at £1,823)
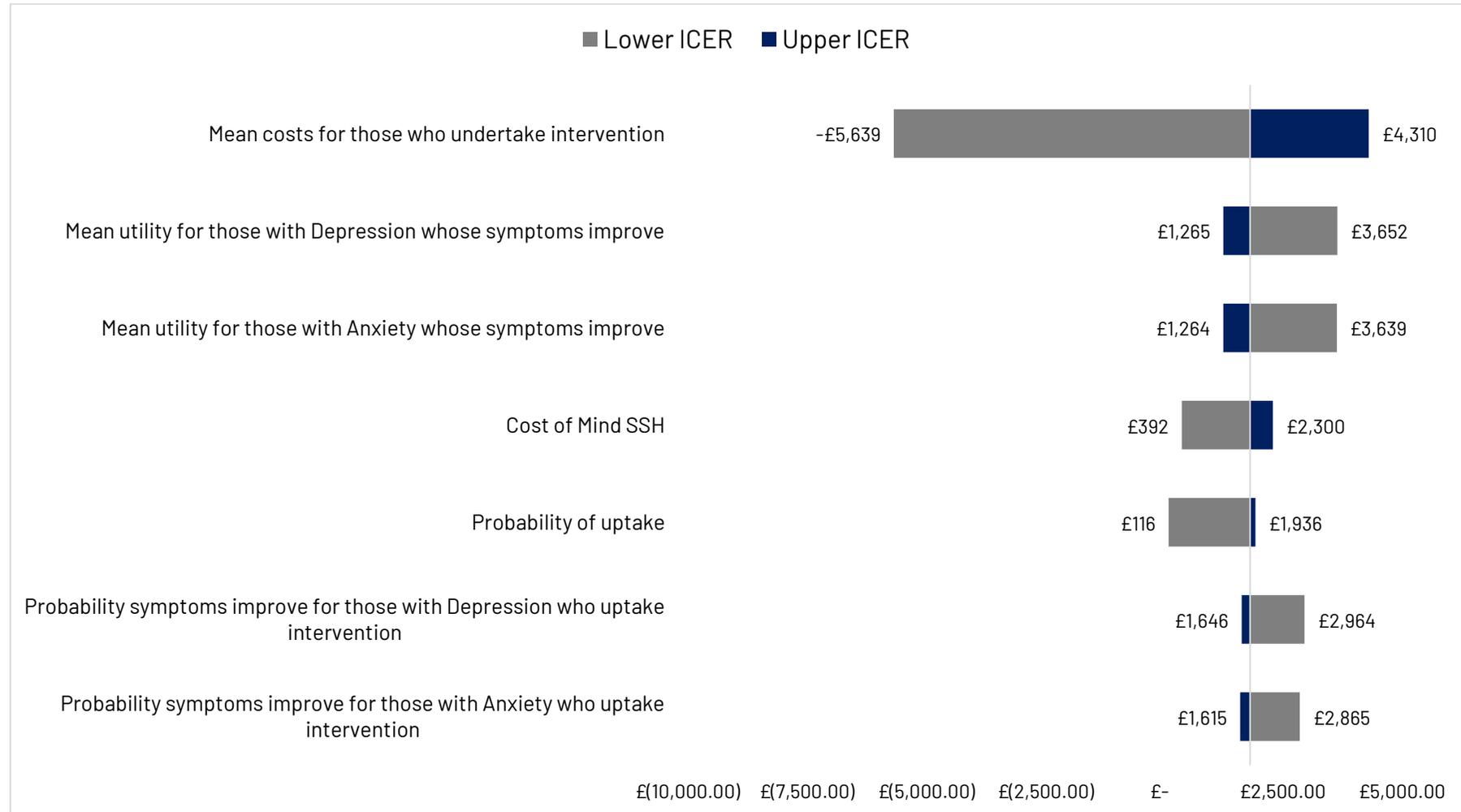
Source: Cost-Utility Analysis – results from separate model running scenario analysis

4.7 Scenario analysis including all staff and variable costs for SSH

Running the CUA including all staffing and variable costs for delivering SSH, totalling £363, makes it possible to check that the initial CUA analysis does not make different conclusions as a result of not including all staff or excluding certain expenditure at local Minds not considered elsewhere in the Richards et al. study.

Table 4.3 presents the model results under this scenario analysis. In this scenario, the cost of SSH is higher relative to the NHS waitlist control by a larger margin of £197, while the average QALY gained by each client of SSH over the 12-month period remains the same. The ICER is positive at £4,368. While this means that SSH does not 'dominate' the waitlist control, the ICER score still lies well below the threshold of £20,00-£30,000 per QALY gained. The NMB for SSH is positive and higher than the waitlist control at each WTP level. Therefore, SSH is still considered cost-effective.

Table 4.3: Deterministic model findings under the scenario analysis

|	Costs (SSH delivery and wider health service)	Effects	ICER	NMB (£20K)	NMB (£30K)
Mind SSH	£648.57	0.8993		£17,338	£26,331
Waitlist	£451.75	0.8543		£16,634	£25,177
Incremental	£196.66	0.0450	£4,368	£704	£1,154

Source: Cost-Utility Analysis – results from separate model running alternative scenario

One-way sensitivity analysis and PSA were undertaken again. The sensitivity analyses found no change in the recommendation to adopt SSH over the waitlist control.

For instance, under the one-way sensitivity analysis presented in **Figure 4.4** reducing the average utility scores reported among those clients whose symptoms improved led to higher ICER results just under £9,000. However, this still is well below the WTP threshold of £20,000-£30,000 per QALY gained. No changes to model inputs result in the ICER increasing up to this threshold.

The PSA continues to find that irrespective of the WTP, SSH remains the recommended strategy to adopt over the waitlist control.

Figure 4.4: One-way sensitivity analysis (Tornado diagram) under the scenario analysis. (Axis starts at £4,368)
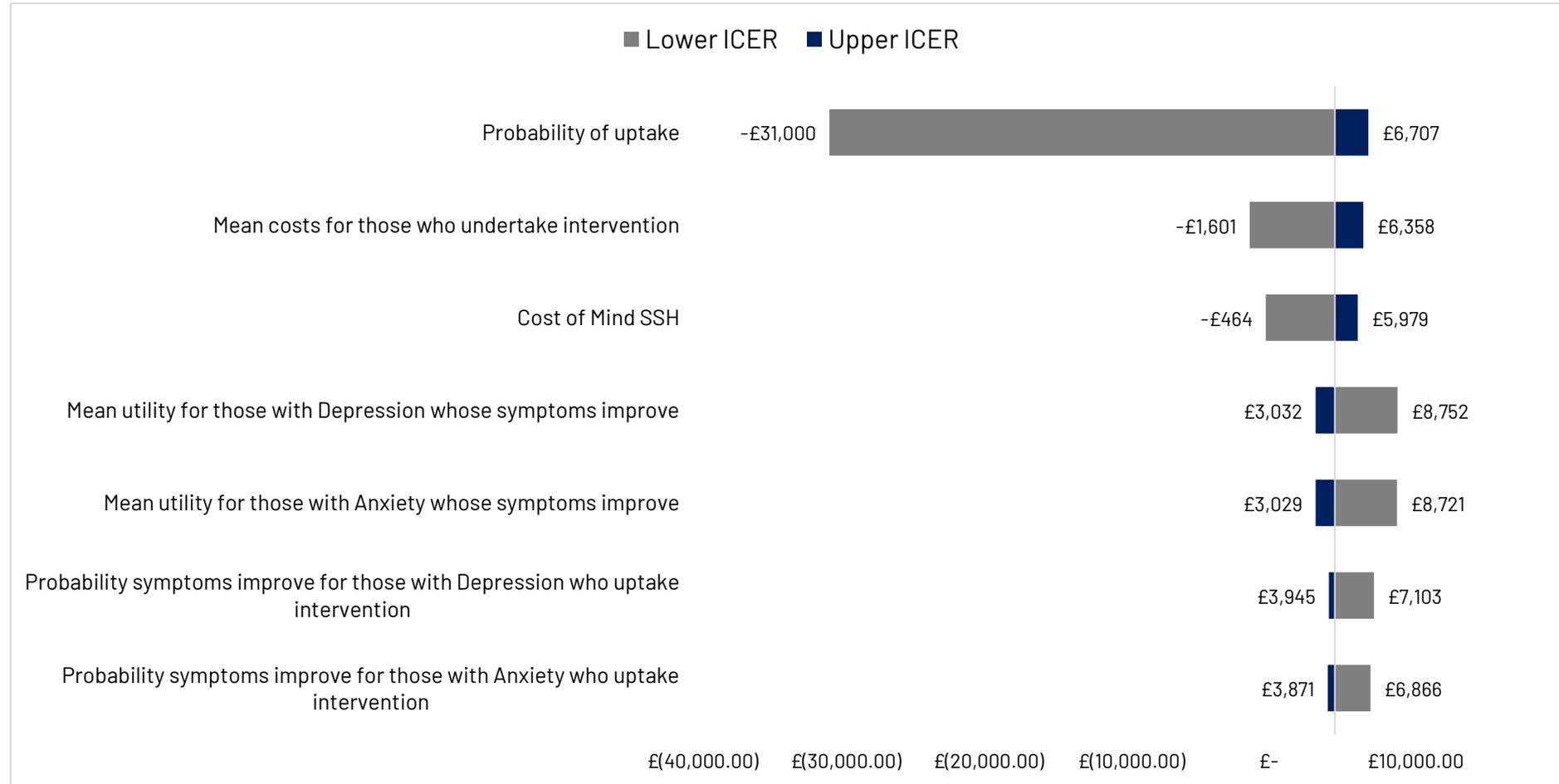
Source: Cost-Utility Analysis – results from separate model running scenario analysis

5 Cost-Consequence Analysis Findings

5.1 Overview

As described previously, the Cost-Consequence Analysis (CCA) is a form of economic evaluation where disaggregated costs are presented alongside a range of consequences (otherwise known as outcomes). For this programme, costs include labour, capital and other costs (including IT materials, recruitment and training costs), and outcomes are based on the GAD-7, PHQ-9, SWEMWBS and EQ-5D-5L scores alongside reductions in wider NHS service use.

A CCA provides an overview of each of the components that make up the costs, broken down to show programme cost drivers alongside the consequences that can show average change over the course of the programme. Category breakdowns can also be compared with other alternative services.

This CCA should be used in isolation to the CUA as it includes a different collection of fixed costs (such as IT set up costs) and these are therefore not included in the CUA. As a result, costs and outcomes from both are not comparable.

The two analyses can be used together to deepen understanding of the intervention and shape decisions about wider adoption and models of delivery.

5.2 Presentation of costs

Costs have been split into the following categories: labour costs, capital costs and other costs (including IT, training, recruitment, materials), with each category presented in separate tables. The costs have been collected from a variety of sources as detailed in **section 3.4** including the local Minds themselves and aggregated to the national level, comprising England and Wales[30]. All costs have been pro-rated to be reflective of the overall programme lifetime (August 2023 – March 2025) to align with the total number of clients and outcomes which were collected over the same timeframe. Therefore, these amounts are *not* per annum figures.

5.2.1 Labour costs

Staff costs are grouped into five categories to align with data collected through Flexigrant and the Qualtrics cost survey. These are: SSH Practitioners, administrators, line managers, clinical supervisors and other staff. For each of these groups, costs were calculated using four steps:

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[30] Only outcome data is available for Wales, and this is limited due to the overlap in system implementation and programme delivery mentioned in section 3.

1 The number of Full Time Equivalents (FTEs) per staff group is totalled up across all local Minds based on their responses to the Flexigrant submission in the second half of 2023/24. The FTE amounts are assumed to stay constant across the full programme lifetime.

2 The total FTE amount is multiplied by an average annual salary for the whole of England and Wales. This average is based on the average salary across all local Minds which completed the Qualtrics cost survey. It is important to note here that this average is based on responses from local Minds which were actively running SSH in late 2024, and therefore the survey was sent exclusively to local Minds in England due to data collection timeframes. However, as the study requires an average salary, it is assumed that average salaries calculated using the Qualtrics cost survey holds constant when considering Welsh Minds[31]. Salaries provided were also in 2024/25 amounts, which has been held constant for the full programme duration as a conservative estimate. This then provides a total cost per staff group. Finally, the salaries are adjusted to include oncosts in the form of a 13.8% National Insurance Contributions and a 4% employer pension contribution.

3 This total cost is then multiplied by the average percentage of time that each staff group has reported they spent on the Mind SSH programme, as reported in the Flexigrant data return, to acknowledge that some staff groups may have other responsibilities outside of their time spent on SSH.

4 This cost represents an annual figure and therefore has been multiplied by 1.7 [32] to reflect the true duration of the programme (from August 2023 to March 2025).

The results of these steps are presented in **Table 5.1.**

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[31] At a local level there are variations in the salary and delivery of the programme that would mean varying geographical costs.
[32] 1.7 is the number of years the programme was active for.

Table 5.1: Presentation of all staffing costs for SSH

	Total number of FTE	Average Salary with oncost		% time dedicated to SSH	Total cost for lifetime of the programme (August 2023 – March 2025)
Practitioners	47.80	£	31,790	100%	£2,531,235
Administrative staff	5.71	£	27,626	6%	£16,058
Line managers	12.57	£	39,231	7%	£59,326
Clinical supervisors	4.47	£	46,253	5%	£17,315
Other staff	4.13	£	46,643	0.4%	£1,337
Total	**74.68**				**£2,625,272**

Source: Analysis of SSH programme costs

As seen in this table, practitioners account for the largest cost of delivering SSH and are the only staffing group assumed to spend 100% of their time on the SSH programme as they were hired specifically to deliver it. A summary of table 5.1 is provided below.

- **Practitioners:** A total of 47.80 FTE, with an average salary of £31,790 including oncosts. All of their time was committed to the programme, with costs from August 2023 to March 2025 totalling £2,531,235.

- **Administrative staff:** Administrative staff contributed 5.71 FTE to SSH with an average salary of £27,626 including oncosts. 6% of their time was attributed to the programme costing £16,058 for their involvement.

- **Line managers:** Managers contributed 12.57 FTE to SSH, with an average salary of £39,231 including oncosts. They spent 7% of their time on the programme, resulting in a SSH-related cost of £59,326.

- **Clinical supervisors:** Supervisors contributed 4.47 FTE to SSH, with an average salary of £46,253 including oncosts. They spent 5% of their time on the programme, leading to a total SSH-related cost of £17,315.

- **Other staff:** A small number of local Minds reported 'other staff' not fitting the above classifications that contributed to SSH. Between them, a total of 4.13 FTE staff were logged. Local Minds reported salaries for other staff in the Qualtrics survey for which the average was taken. These are similar to the salary of clinical supervisors at £46,643 including oncosts. These staff also spent a small amount (0.5%) of their time on the programme leading to a total SSH-related cost of £1,337.

The total labour costs across these groups were **£2,625,272** driven by practitioners that contribute 96% of the cost.

5.2.2 Capital costs

Capital costs for SSH consist solely of room rental from which staff conduct assessment sessions or appointments, totalled over the full duration of the programme. This cost was calculated through three main steps:

1 The number of hours a room was reserved for per week was taken from a Qualtrics survey that was distributed exclusively to the English local Minds. The total number of hours the room was reserved for was used, rather than the number of hours a room was actually used for – a conservative estimate. As above, however, it is important to note here amounts are based on responses from local Minds which were still running SSH in late 2024. To mitigate this, it is assumed other local Minds which did not receive or respond to the Qualtrics survey (a further 13 Minds) would have reported the same number of hours.

2 The total number of weekly hours has then been prorated to reflect the total hours of the lifetime of the programme from August 2023 to March 2025.

3 This was then multiplied by an average hourly rental cost of £3.33[33]. This rental cost was based on a small, sole use, community room based on a comparable health and social care programme that required space for staff to use small rooms to hold consultations or face-to-face clinics. This serves as a 'market rate' that represents demand for renting room space to run community healthcare services, so as not to use larger rental charges for local Mind offices which are not entirely used for the service. This is a mid-range estimate when compared with other reported rates[34].

As a programme with online components, the capital overhead costs for conducting SSH are relatively low. Some local Minds fed back to the study team that they run the programme fully virtually with no office use at all. In instances where a room has been reserved across the English local Minds this has totalled 258 hours per week. This scales up to 405 hours assuming the Welsh local Minds (or any other local Minds which did not log their hours) reserved the same hours. When scaled up to the duration of the programme, this suggests 35,047 hours of rooms were rented.

Based on these assumptions, the total capital cost of the SSH programme over its lifetime is estimated to be **£116,823**. **Table 5.2** sets out this cost.

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[33] Rental amount derived from: https://www.elmbridge.gov.uk/community-support/centres-community/centres-hire
[34] From a review of rental fees, the lower and upper rates for renting community spaces rental rates were sourced from https://waterloocc.co.uk/room-rental/ and https://rooms.relationalspaces.co.uk/ respectively.

Table 5.2: Presentation of all capital costs for SSH

	Number of hours rooms were reserved for over the lifetime of the programme (August 2023 – March 2025)	Average hourly rental and utility costs	Total rental and utility costs (August 2023 – March 2025)
Total	35,047	£3.33	£116,823

Source: Qualtrics survey, Ipsos analysis, 2025

5.2.3 Other costs

Costs besides staffing and capital are a mix of set-up and delivery costs. This includes:

- **IT platform costs for Views and Limbic**. Based on information provided by national Mind , Views cost £94,603 for an agreement from May 2023 to May 2025. This consisted of costs to design and build the system of £60,000, and licenses for £34,603. As the Views service agreement runs over the full programme lifetime this is not prorated further. Limbic has a software license agreement in place from January 2023 to January 2025, which cost £300,000. As the Limbic subscription terminated in January 2025 and did not take further referrals, this specific cost amount is not prorated until programme end at March 2025.

- **Equipment to support working (e.g. phones and laptops for practitioners) and recruitment materials including advertisements and induction materials**. Each of these amounts is reported in the Flexigrant submission for the second half of 2023/24 and annualised. These costs are assumed to be set-up activities and are not prorated for the remainder of the programme.

- **Materials to promote the SSH intervention and encourage uptake and 'other' costs such as printing and office costs**. Each of these amounts is reported in the Flexigrant submission for the second half of 2023/24 and annualised. These costs are assumed to be ongoing delivery activities and are prorated.

The cost of training is also reported here, with three different delivery costs considered under the CCA:

- Training provided centrally by national Mind, which involved a Senior Programme Officer and Programme Officer for the full duration of the programme. With 18 sessions from 8 Sept 2023 to 19 Nov 2024 and four additional sessions, the cost of these staff delivering the sessions totalled £6,009. This is *not* prorated as it is already the lifetime cost for the programme.

- eLearning materials developed centrally, by a Senior Programme Officer, over 35 hours totalling £852. This is *not* prorated as it is already the lifetime cost for the programme.

- In the second half of 2023/24 across local Minds in England and Wales, a further £38,354 was logged for locally delivered training. This is local training which varied at each local Mind including first aid, safeguarding and young people's mental health training. This amount is annualised and then prorated further to cover the full programme lifetime from August 2023 to March 2025.

Table 5.3 shows the total costs for each of the components mentioned above, split into the set-up and delivery costs. All but the IT platform license costs are considered set-up costs. For these set-up costs they may have use beyond the programme for example, the phone provided to a practitioner may be used for other programmes

Table 5.3: Presentation of other costs for SSH

	Set-up Costs	Delivery Costs for programme lifetime (August 2023 – March 2025)	Total Costs
Views	£ 60,000	£34,603	£ 94,603
Limbic		£300,000	£300,000
Training (central)		£ 6,861	£ 6,861
Training (local)		£ 37,581	£ 37,581
Equipment	£ 82,712		£ 82,712
Materials		£ 47,137	£ 47,137
Other		£ 169,971	£169,971
Recruitment	£ 16,100		£ 16,100
Total	**£ 158,812**	**£596,153**	**£ 754,965**

Source: Analysis of SSH programme costs

This table shows that:

- IT platforms (Views and Limbic) add **£394,603** in cost to SSH.

- All set-up costs for SSH (including the implementation of Views, equipment and recruitment activity) total **£158,812**.

- All delivery costs relating to programme delivery are higher than set-up costs and comprise the running of the IT systems, training for staff, materials and other costs. These total **£596,153**.

In total, other costs contribute **£754,965** to the programme.

5.2.4 Cost breakdown

The programme is made up of the three cost categories. Broken down, it is evident that labour is the biggest cost driver of the programme.

- Labour costs total **£2,625,272** for the full programme lifetime (August 2023 to March 2025) and contribute 70% to the total programme cost.

- Capital costs total **£116,823** for the full programme lifetime and contribute 4% to the total programme cost.

- Other costs (comprising IT, training, equipment, materials, recruitment and other) total **£754,965** for the full programme lifetime and contribute 22% to the programme cost. Within this category, IT costs are 11% of the total programme costs at **£394,603**.

This gives **a total programme cost of £3,497,060**[35]. When considering the total number of clients with digital records for which data was available (10,912[36]), this gives a total **cost per client of £320**[37]. Setting up and licensing Views and Limbic was a significant decision Mind made when considering the service model for SSH, and it has sought feedback on this from stakeholders and users. As an illustration, if IT systems are excluded from the total cost this brings the total amount of the programme down to £3,102,457 and the total cost per client becomes £284, demonstrating the large contribution of these systems to total cost. The evaluation did not assess the effect this potential change would have on the quality of service delivery.

When breaking down IT into set-up and delivery costs, the former (covering IT development, equipment and recruitment) totals £158,812 (5% of the programme's cost over its lifetime) while the latter (covering staffing, rent, training, materials and other costs) totals £3,338,248 (95% of the programme cost).

5.3   Presentation of consequences

5.3.1 Client outcomes

Consequences, or intervention outcomes, are presented in **Table 5.4** and **Table 5.5** below.

Table 5.4 shows the average total score and range for each of the mental and physical health and wellbeing measures (detailed in section 3.2) across the entire English and Welsh population that

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[35] This total cost should be considered with the listed assumptions that have been made throughout section 5.

[36] This figure considers only those with digital records for which information was made available. Individuals that were recorded before the implementation of the digital IT systems are not considered or included as data is not available.

[37] If there are more clients than the data that has been made available. it may be that the cost per client is lower than what is reported.

received the Mind SSH intervention. It also shows the sample size for each relevant metric, highlighting the dropout rates at each level with the fewest individuals logging EQ-5D-5L scores.

All measures show improvement through to session 5. The most significant gains however are observed between the pre-intervention period and session 3, with a diminishing rate of improvement between session 3 and 5.

Table 5.4: Presentation of consequences

	Pre intervention Average *[Range]*	Session 3 Average *[Range]*	Session 5 / Endline Average *[Range]*
SWEMWBS Score	18.48 *[7 – 34]*	21.96 *[7 – 35]*	23.45 *[7 – 35]*
SWEMWBS Sample Size	5,667	2,932	1,881
EQ-5D-5L Score	0.71 *[-0.29 – 1]*	0.79 *[-0.24 – 1]*	0.83 *[-0.16 – 1]*
EQ-5D-5L Sample Size	6,344	2,850	1,783
GAD-7 Score	13.45 *[0 – 27]*	6.45 *[0 – 27]*	4.18 *[0 – 27]*
GAD-7 Sample Size	9,528	4,665	3,623
PHQ-9 Score	12.34 *[0 – 21]*	6.06 *[0 – 21]*	3.88 *[0 – 21]*
PHQ-9 Sample Size	9,537	4,672	3,631

Source: Views data provided by Mind, 2025
Note: The minimum score on the SWEMWBS scale is 7 as this would be the total of the lowest score (1) for each of the 7 subcomponents. As a result, all scores below 7 for SWEMWBS have been removed as this indicates incorrect scoring.

As the ranges suggest in **Table 5.4,** some individuals have been recorded as having no signs of anxiety/depression and/or consider themselves in full health at the pre-intervention stage (0 in the GAD-7 and PHQ-9 and 1 in EQ-5D-5L). Given the intention of the programme to support those with mild to moderate mental health problems, those who had these scores have been removed in **Table 5.5**. This is not the case for SWEMWEBS at the baseline stage, as no client reported a score of 35.

Table 5.5: Presentation of improvement in consequences excluding those at the high end of each scale

	Pre intervention Average [Range]	Session 3 Average [Range]	Session 5 / Endline Average [Range]
SWEMWBS Score	18.5 [7 – 34]	22.0 [7 – 35]	23.5 [7 – 35]
SWEMWBS Sample Size	5,667	2,932	1,881
EQ-5D-5L Score	0.71 [-0.29 – 0.95]	0.79 [-0.24 – 1]	0.82 [-0.16 – 1]
EQ-5D-5L Sample Size	6,212	2,798	1,751
GAD-7 Score	13.39 [1 – 21]	6.99 [0 – 21]	4.76 [0 – 21]
GAD-7 Sample Size	8,787	3,935	2,898
PHQ-9 Score	15.00 [1 – 27]	7.62 [0 – 27]	5.50 [0 – 27]
PHQ-9 Sample Size	8,547	3,935	2,660

Source: Ipsos analysis of Views data, 2025

Given these changes, findings show an improvement across all measures, with similar size effects from pre-intervention to session 3 and smaller positive effects from session 3 to session 5:

- **SWEMWBS** shows a **3.48 point improvement from pre-intervention to session 3** and **1.49 point improvement from session 3 to session 5**, showing an **average 4.97-point improvement** over the lifetime of the SSH intervention. This is considered above the minimum detectable change[38] (2 points[39]) threshold to demonstrate a change in an individual's mental wellbeing.

- **EQ-5D-5L** shows a **0.08 point improvement from pre-intervention to session 3** and **0.03 point improvement from session 3 to session 5**, showing an **average 0.11-point improvement** over the lifetime of the SSH intervention. This is considered above the minimum detectable change[40] (0.04 points[41]) threshold to demonstrate a change in an individual's overall health.

- **GAD-7** shows a **6.40 point improvement from pre-intervention to session 3** and **2.23 point improvement from session 3 to session 5**, showing an **average 8.63-point improvement**

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[38] https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/about/wemwbsvsswemwbs/
[39] The study suggests a minimum detectable change is between 1 and 3 points, therefore the average of 2 points is used
[40] https://pubmed.ncbi.nlm.nih.gov/30224114/#:~:text=Methods:%20We%20used%20longitudinal%20survey,similar%20results%20for%20patient%20subgroups.
[41] The study suggests a minimum detectable change is between 0.03 and 0.05 points, therefore the average of 0.04 points is used

over the lifetime of the SSH intervention. This is considered above the minimum detectable change[42] (4 points) threshold to demonstrate a change in an individual's levels of anxiety.

- **PHQ-9** shows a **7.38 point improvement from pre-intervention to session 3** and **2.12 point improvement from session 3 to session 5**, showing an **average 9.50-point improvement** over the lifetime of the SSH intervention. This is considered above the minimum detectable change[43] (5 points) threshold to demonstrate a change in an individual's levels of depression.

Table 5.6 shows the number of individuals that have experienced a positive[44] minimum clinically important difference (MCID). This is the minimum amount that an individual needs to move on the scale in order for the difference to be considered substantial to affect their wellbeing or health. Table 5.6 shows the point difference that an individual needs to move for each of the measures and then the number of people that have moved by an amount considered clinically different. As can be seen, there is a greater number of people who have experienced MCID from pre-intervention to session 3, than from session 3 to session 5. Despite this, this table highlights the importance of the fifth session, as there are still large volumes of people experiencing positive MCID, particularly for those being measured on the GAD-7 scale (anxiety).

Table 5.6: Number of individuals that undertook SSH and experienced positive MCID

	Minimum Clinically Important Difference (MCID)	Number of individuals that have experienced a positive MCID from pre-intervention to session 3	Number of individuals that have experienced a positive MCID from session 3 to session 5
SWEMWBS	2[45]	1,696	928
EQ-5D-5L	0.04[46]	1,416	575
PHQ-9	5[47]	2,137	572
GAD-7	4[48]	2,392	1,700

Source: Ipsos analysis of Views data.
Note: 1. It is noted that the data reports some large fluctuations in score movement from pre-intervention to session 3 and session 3 to session 5 (full reductions in scores to perfect scores or near perfect). This is the case for less than 5 % of records.

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[42] https://www.sciencedirect.com/science/article/abs/pii/S0165032719313643

[43] https://pmc.ncbi.nlm.nih.gov/articles/PMC3281149/#:~:text=Scores%20of%205%2C%2010%2C%2015,less%20than%205%20represents%20remission.

[44] They have moved in a positive direction on the scale, for SWEMWBS and EQ-5D-5L they have increase by the relevant amounts up the scale, and for PHQ-9 and GAD-7 they have decreased by the relevant amounts down the scale.

[45] https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/about/wemwbsvsswemwbs/ - the MCID ranges from 1-3, an average of 2 has been used

[46] https://hqlo.biomedcentral.com/articles/10.1186/s12955-024-02294-3 - the MCID ranges from 0.03 to 0.05, an average of 0.04 has been used

[47] https://pmc.ncbi.nlm.nih.gov/articles/PMC3281149/#:~:text=Scores%20of%205%2C%2010%2C%2015,less%20than%205%20represents%20remission.

[48] https://pmc.ncbi.nlm.nih.gov/articles/PMC3281149/#:~:text=Scores%20of%205%2C%2010%2C%2015,less%20than%205%20represents%20remission.

Samples in this table show some extreme movements on either end of the scale (full reductions or improvements on scale from pre-intervention to session 3 or session 3 to session 5, across all measures). Ipsos has made no assumptions about the legitimacy of these movements. Only if data is missing has it not been included.

5.3.2 Reductions in service use

The intervention also looked at self-reported contacts to services. **Table 5.7** shows the average contacts to GP, hospital outpatient and IAPT/Talking therapy resources for client pre-intervention and by session 5. These measures were only recorded at the assessment stage (pre-intervention) and then at the end of the session (session 5). Across all services average contact has reduced. This is most prominent with GP contacts, particularly for those contacting the GP for mental health reasons.

Table 5.7: Presentation of improvement in service use outcomes

	Pre intervention Average	Session 5 / Endline Average	Difference pre and post intervention
GP for mental health	1.25	0.83	0.42
GP for other reasons	1.30	0.95	0.35
IAPT/NHS Talking Therapies	0.28	0.20	0.08
Hospital outpatients for mental health	0.09	0.05	0.04
Hospital outpatients for other reasons	0.44	0.33	0.11

Source: Ipsos analysis of Views data, 2025

Table 5.8 shows the average cost of an appointment for the GP, IAPT and hospital outpatient appointment[49] and multiplies this by the number of average contacts to each of the relevant services, allowing an inference of a potential cost saving as a result of the reduced average service use per SSH client.

1 **GP contacts:** To estimate potential cost savings resulting from reduced average GP visits, the average cost of GP contacts was calculated before and after the intervention. The average cost of a 10-minute GP appointment (£45[50]) was multiplied by the average number of

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[49] For the CCA, costs associated with NHS appoints have been multiplied by an inflator using the Bank of England inflation calculator: https://www.bankofengland.co.uk/monetary-policy/inflation/inflation-calculator
[50] Unit Cost of Health and Social Care 2024, PSSRU, https://www.pssru.ac.uk/unitcostsreport/. £45 per 10-minute appointment including direct care staff costs and qualification considerations.

contacts reported by clients both pre- intervention and at session 5. This average level of service reduction would correspond with an average cost saving of £19 per client in GP costs related to mental health and £16 per client for other health reasons.

2 **IAPT/NHS Talking Therapies contacts:** To estimate potential cost savings resulting from reduced average IAPT/NHS Talking Therapies, the average cost of an IAPT session (£154[51]) was multiplied by the average number of contacts reported by clients both pre-intervention and at session 5. This average level of service reduction would correspond with an average cost saving of £12 per client in IAPT/NHS Talking Therapies related contact costs.

3 **Hospital Outpatient contacts:** To estimate potential cost savings resulting from reduced average hospital outpatient contacts, the average cost of a hospital outpatient appointment (£156[52]) was multiplied by the average number of contacts reported by clients both pre-intervention and at session 5. This average level of service reduction would correspond with an average cost saving of £6 per client in hospital outpatient costs related to mental health and £17 per client for hospital outpatient costs for other health reasons.

Table 5.8: Potential service use cost savings

	Cost of average service use pre-intervention	Cost of average service use at session 5	Potential cost savings to the system per client
GP for mental health	£ 56	£37	£19
GP for other reasons	£ 59	£43	£16
IAPT/NHS Talking Therapies	£ 43	£31	£12
Hospital outpatients for mental health	£ 14	£8	£6
Hospital outpatients for other reasons	£ 69	£51	£17

Source: Ipsos analysis, 2025

Limitations of the CCA

The CCA is based on data collected from a range of sources and should be interpreted with the below in mind:

[51] https://digital.nhs.uk/data-and-information/publications/statistical/patient-level-activity-and-costing/2020-21 . The total value of appointments in 2022 has been divided by the total number of appointments in 2022 to provide an average appointment cost of £135.68. This has then been inflated to April 2025 costs.

[52] https://www.england.nhs.uk/2018/10/nhs-to-trial-tech-to-cut-missed-appointments-and-save-up-to-20-million/ .. The cost of an appointment in 2018 (£120) has been inflated to April 2025 costs.

- The salary for labour is based on the cost survey sent exclusively to English local Minds and therefore does not consider the salaries for Welsh local Minds and thus any geographical differences in staff pay, despite the coverage of the programme. This is also true for room utilisation.

- The number of FTE is based on the number that was reported during the latest Flexigrant submission in H2 2023/24. This analysis has not considered the gradual recruitment of individuals and has made the assumption all staff have been present for the lifetime of the programme.

- The proportion of time staff spent on the SSH programme is based on Flexigrant data from all local Minds. This asks local Minds to report the percentage of direct vs indirect time spent on the programme. For the practitioners, it is assumed that 100% of time is spent on the programme, as they were recruited solely for SSH, and direct vs indirect refers to patient contact time. For the administrative, line manager, clinical supervisor and other staff groups, the direct time is assumed to be spent on the programme, and the indirect is assumed to be spent on other responsibilities outside of the programme given the proportions registered as it is assumed they were deployed from existing staff.

- Capital costs per hour are based on external third-party rates for one location in the UK and do not consider geographic variation.

- Where data was combined across Flexigrant and the Qualtrics collection, care had to be taken to combine some information that did not align perfectly. For example, when reporting other staff, a small number of local Minds reported 'other staff' FTE amounts in Flexigrant (just over 4 FTE). However, the same local Minds did not report salaries for 'other staff' in the Qualtrics survey. For this reason, a conservative estimate had to be made when considering who these staff were, and salaries in line with clinical supervisors of £46,643 were set for them.

- The cost per client is based on 10,912 clients given the data provided for the evaluation. This is data that was made available via the digital platforms and the figure for the lifetime of the programme may well be higher as it will include those who accessed the service before the IT systems were implemented.

- Samples in table 5.6 show some extreme movements on either end of the scale (full reductions or improvements on scale from pre-intervention to session 3 or session 3 to session 5, across all measures). Ipsos has made no assumptions about the legitimacy of these movements. Only if data is missing has it not been included.

6 Discussion of findings

6.1 Considerations for SSH programme delivery

Perceived economy and efficiency of SSH: Different aspects of SSH have been praised by staff at Mind for achieving positive results at pace and at a low cost. In consultation with members of the Lived Experience Advisory Panel (LEAP) at the end of the project that the costs presented appeared to be better managed than that of the NHS Talking Therapies equivalent, however they did add caution that the breakdown of programme costs including oncosts and overheads are kept in mind. Resources such as the development of an e-learning training course for practitioners represent a very small cost (£852 in total) within the CCA and were considered a success by those managing the programme. Beyond the immediate findings above, Mind staff note that team members problem-solved and developed a range of marketing, managerial, and technical resources at pace.

Choices for the delivery model: The delivery model for SSH has central aspects such as the programme guidelines and IT systems costs and use set nationally, while service delivery itself is local. This allows for some varied implementations by local Minds to suit their needs. In preparing the CUA and CCA, local variation in staff salaries and hours, set-up costs and expenditure on materials were noted (for example, some overspent on budgets due to paper copy requests). This flexibility can be beneficial. However, providing flexibility over service delivery does require care to ensure that value for money is maintained by area.

For future delivery of SSH, it remains relevant to have clear and overarching national guidelines for the service, and then to define roles and expectations clearly among national and local Minds. This includes consistency in understanding which aspects of the service model (such as staffing, running of appointments, use of central systems, reporting) are set consistently at a national level, and which vary.

As part of delivering SSH in future, the LEAP also noted that further aspects around how the programme is delivered may be important for maximising client outcomes. For instance, setting up the end of the programme to prevent clients experiencing a cliff edge moment following the completion of SSH. LEAP also noted that allowing for re-referral may support this.

Cost drivers: The results of this evaluation could support scaling of SSH to a greater number of potential clients across England and Wales, or to introduce the intervention to new areas. In doing so, the key cost drivers identified in the CCA are relevant to consider for Mind at a national level as well as individual local Minds delivering the service. The cost drivers are: staffing, IT and a variety of sunk or set-up costs. The following points are worth considering:

- The CCA demonstrates that **sunk and set-up costs** total 5% of programme costs. As the programme expands, set-up costs should be managed down further (meaning a greater share

of costs will be direct delivery of the service by staff). Mind can benefit from economies of scale by centrally coordinating the procurement of necessary equipment.

▪ Scaling may lead to increases in overall **IT license costs** for platforms like Limbic. Ongoing license costs are £334,603, but how this amount changes in future depends on how the pricing for software licensing is structured. While the cost per user may fall at scale, this will depend on pricing and negotiation arrangements in place. Further discussions with IT providers may also offer opportunities to automate data collection or integrate data in different ways to reduce data entry – which would greatly support efforts to drive data completeness. This may incur additional expense but could also save time and improve reliability in collecting data for ongoing monitoring and evaluation.

▪ Programme costs are primarily driven by **staffing**, with over £2.5 million spent on SSH practitioners for the lifetime of the programme, with a leaner amount of spend on managerial staff. Of this, the majority of practitioner time (up to 78% of their time) is spent in direct contact with clients. Extending the service will require further recruitment of practitioners, which has been done individually by local Minds. The amount spent on recruitment materials varies widely; local salaries which do not align to a standard pay scale have been set. At scale, it may be beneficial to centralise some aspects of recruitment and staffing (as well as re-use recruitment resources already produced at programme set-up, especially as the programme learns what works well in this regard) while recognising each local Mind undertaking SSH is doing so independently and retains control over local delivery.

Coverage of client sub-groups: While these pathways were not considered by this evaluation, the study team has observed a high degree of variety in which clients use SSH. This is in terms of both the variety and severity of outcomes which are scored lower at referral or assessment. At one extreme, some clients with more severe conditions than Mind envisaged for the type of intervention registered to the programme. While the CUA and CCA focus on average improvements across all clients, there are questions to consider on the extent to which SSH will have provided a suitable replacement for these users.

6.2   Use and communication of study findings

The intention of this evaluation is to provide Mind with a shared understanding of the findings. The study has been a considerable undertaking for staff across Mind ranging from senior management to those delivering the service, working in communications, grant distribution and the local service teams.

The **results of the CUA are encouraging and show the intervention leads to better outcomes while reducing costs relative to the NHS waitlist control group**. These findings place Mind in a strong position to speak with stakeholders and peers about the programme's viability.

The overall evaluation findings can be translated into accessible and relevant materials for NHS and policy decision-makers messages, highlighting:

- SSH is cost-effective and 'dominant' relative to the study control group. This is consistent when varying key assumptions and parameters.

- There are wider societal benefits that arise as a result of improvements in client quality of life. This includes improved productivity, such as paid or unpaid contributions to society, and reduced consumption of public services. In total, each client generates an estimated £27,240 in benefits which is higher than the wider social benefits that arise in the control group.

- The CCA presents improvements in multiple clinical indicators for clients, as well as reduced use of wider NHS services.

Given the documented challenges in accessing support for individuals with mild- to moderate-mental health problems, the results presented here support the case for inclusion of SSH in local mental health pathways which complement other routes for more severe cases.

While delivery and funding will often take place locally, the national Mind team should also consider how SSH supports it to have strategic conversations at the national level regarding opportunities across England and Wales. There could be opportunities to feed into policy conversations around the role of the voluntary sector in mental health provision, or to engage with national bodies such as NHS England, the regional Health Innovation Networks, professional networks, conferences or sector publications to raise awareness for the programme.

6.3   Areas for further consideration by Mind

Comparing results with other CBT interventions

While the economic evaluation of SSH shows it to be cost-effective relative to the NHS waitlist control, it is recognised that there are other voluntary and commercial providers of support interventions which offer virtual or in-person CBT services and resources over regular support meetings. Potential funders may view SSH alongside other iCBT and mental health support options to commission.

These other self-help interventions, which have been evaluated elsewhere are likely to have undertaken different evaluation approaches. Where they have done this, they may not have comparable population characteristics, delivery models or outcome measures. The only direct comparison this study draws is to a control group of individuals on the NHS waitlist.

Some studies may draw on similar approaches, for example gathering data to construct a control group from the Richards et al. study. However, even in this case it is important to understand any differences in the treatment and control groups in these studies and this evaluation of SSH. The CUA study also uses a bespoke modelling approach and structural assumptions in this model may differ from those applied in other studies.

The study team therefore advises Mind to apply a high degree of caution if attempting to compare net monetary benefits across studies for other interventions, or in drawing like-for-like conclusions.

While Mind may separately review studies carried out on other interventions (and there may be rich learning for SSH from other models), caution is advised in drawing any direct comparisons to other standalone evaluations of interventions. Communication with stakeholders on these results should centre on the intervention being *dominant* as a recommendation for individuals with mild-to-moderate depression or anxiety *relative to the strategy not to commission a service*. Communications should note the alignment with NICE guidelines suggesting the programme represents value for money, and highlight the evidence which shows SSH contributes to observable benefits across multiple outcome domains, service use reductions and wider societal benefits.

Learnings from delivery of IT systems and data collections for future research and evaluation

As part of the research carried out by the McPin Foundation and Ipsos, Mind has reflected on practical learnings and challenges in relation to the use of IT and data collection systems as part of SSH, where these were implemented after the programme launched in Wales. Some of these practical reflections were:

- At the beginning of delivery in 2023, IT systems were not yet established and there was also an initial surge in clients referred. This has meant that records for clients who were referred to the service prior to August 2023 were not logged or counted in the systems. Therefore, they are also not included in count of 10,912 referrals used in the evaluation.

- This evaluation also includes data from Views across both England and Wales. However, SSH in Wales concluded in March 2024. Given that IT systems were only in place from August 2023, records available for this evaluation mostly represent clients based in England (90% of overall clients). Follow-up requests for information have also only approached local Minds which are actively running SSH in England.

- While the roll-out of IT systems has impacted on the cost of delivering the service, and may have altered the service experience for users and therefore their outcomes from it, roll-out of the systems was not designed in such a way to isolate specific improvement from introducing it, for instance through staggering its roll out across local Minds. While we can observe that excluding IT services reduces service costs by £394,603 it is challenging to establish a causal relationship between the quality of the IT service and its ability to refer, manage and collect data on clients.

- Since their introduction Flexigrant, Qualtrics, Limbic and Views systems have each been important for capturing data on clients and programme costs. The data collected has been sufficient to provide a conclusive CUA result, however risks have still persisted in gaining complete and high-quality data from each system. There remain challenges in incentivising

or managing local Minds to provide data alongside a variety of other urgent commitments. Additionally, while practitioners received training to deliver the SSH sessions and record data, there could have been more communication with practitioners on the importance of the data for the economic evaluation.

Addressing the above challenges can be mitigated in each future programme through early involvement and scoping with and suppliers of data system and evaluators at the point at which an intervention is designed. This can create consensus around evaluation questions before launch, ensure systems are designed at the outset to gather key information, and to recommend any changes to programme design which suit the evaluation such as phased or staggered implementation of systems or programme elements. As part of this, it is also valuable to develop guidance, plans or systems from the outset which will support increases in the response rate among clients completing surveys and data collections.

Additional considerations for future research and evaluation

The study team designed the evaluation based on the nature of SSH as an intervention, the requirements for demonstrating the cost effectiveness and range of benefits of the programme, and the available data. A range of questions remain. Moving beyond the evaluation and as part of continuing and scaling SSH, there remain key research questions. These may be:

- As a programme, which sub-groups of clients benefited from SSH, and how did their experience differ according to demographics, condition or by SSH pathway followed. Each pathway under SSH related to specific requirements such as depression, anxiety and low self-esteem. However, the design of this research has focused on the cost-effectiveness and outcomes of SSH as a whole.

- Future studies may wish to specifically seek to separate out sub-groups of clients, examine in detail what resources and support individual pathways, examine specific learnings or refinements to the pathways approach, and directly consider whether SSH has enabled equitable access to support services for certain demographic groups. Based on what has been observed across local Minds, how much variation there is in model delivery, and how this influences programme costs and outcomes.

- Whether there any cost savings to be made and whether these affect outcomes.

- Exploration of further individual gains as a result of face-to-face sessions and the quality of the SSH sessions. The impact of these could result in societal gains that this report has not explored.

- Whether there are further opportunities to maximise client response to follow-up surveys. The LEAP suggested that designing or distributing incentives to fill these surveys may increase response rates.

While some of this information will be available to consider through Views, other analysis such as of pathways and sub-groups may require dedicated additional data collection or dedicated changes to how the programme is run and monitored in future. It may also require a mix of data collection as well as qualitative discussion and exploration of next steps with local Minds.

Annex 1: Summary of Richards et al. (2020) study on SilverCloud iCBT

Richards et al. have undertaken significant research to evaluate the clinical and economic impact of SilverCloud's internet-delivered cognitive behavioural therapy (iCBT) programmes within routine NHS care, specifically under the Improving Access to Psychological Therapies (IAPT) initiative in England.

This study implemented a randomised waitlist-controlled trial into routine Step 2 IAPT services. Participants referred for treatment with symptoms of depression or anxiety were randomly assigned in a 2:1 ratio to receive either immediate access to SilverCloud's guided iCBT or to a waitlist group, with access to the programme after eight weeks. The iCBT intervention—either *Space from Depression* or *Space from Anxiety*—consisted of an eight-week structured programme of CBT content delivered online, supported weekly by Psychological Wellbeing Practitioners.

The choice of a waitlist control was both methodologically and ethically sound. It provided a valid comparator to detect treatment effects while ensuring that no participant was denied care in the longer term, which would have been inappropriate.

Primary outcomes were measured using validated scales: the PHQ-9 for depression and the GAD-7 for anxiety. Additional measures included the Work and Social Adjustment Scale (WSAS) and the EQ-5D to assess health-related quality of life. Participants were assessed at baseline, eight weeks, and at follow-up intervals extending to 12 months to evaluate both immediate and sustained effects. Structural decisions taken when conducting the Decision Tree model for evaluating SSH (for instance, presenting findings over 12 months and comparing EQ-5D-5L, GAD-7 and PHQ-9 results, are done in alignment with the Richards study.

Findings published in 2020 confirmed that SilverCloud's guided iCBT produced statistically significant reductions in symptoms of depression and anxiety compared to the waitlist control at eight weeks. Improvements were also observed in functional impairment, and effects were largely maintained over the 12-month follow-up period. The trial used an intention-to-treat (ITT) approach, reflecting the realities of service delivery and ensuring a conservative estimate of impact.

The research was carried out to a high methodological standard. It was conducted and reported in line with CONSORT guidance for Randomised Controlled Trials, used rigorously validated outcome measures, and applied robust statistical and economic methods. The 2020 study and supplementary materials provide additional data on the model and approach, and are publicly available via the journal publisher at https://www.nature.com/articles/s41746-020-0293-8.

Annex 2: Theory of Change developed during study scoping

Legend:
- Provider (Mind)
- Societal
- NHS
- Service users

Context

Demand for talking therapies significantly outstrips current statutory provision.

People find it hard to access timely support for mental health problems. Without timely support, problems can escalate.

Digital interventions are accepted and acceptable to many. A choice for f2f/remote mental health support is preferred.

Mind, as a national organisation with local reach has the trust, credibility, understanding and expertise to reach people to access early intervention support.

Mind's evidence-based SSH intervention is shown to be effective and high quality. But increasing number of providers are coming to the market and being commissioned by health services. The infrastructure, quality and evidence base needs to be robust to allow Mind to compete.

There are a range of different stakeholders that Mind need to engage to scale SSH, including local Minds, national Mind senior management team, health professionals and other referral partners

Rationale

Mind's Supported self-help intervention empowers people to help themselves and as both a digital and f2f intervention, it has been shown to be effective for reducing anxiety, depression and improving mental wellbeing

Mind wants to scale this intervention to meet the unmet needs of people with low to moderate levels of mental health need to prevent mental health problems from escalating.

Mind aims to develop the service with a digital front door for easy self-referral and referral from health professionals and others to enable timely access to support.

By scaling and promoting the service in community settings, this will help to reduce the stigma of mental health issues and normalise the process of seeking support

Inputs

Funding for national programme infrastructure (digital platform and CMS, programme staff; marketing; training; evaluation).

Funding for local delivery (practitioners, volunteers, marketing and communications, local system engagement, targeted engagement to engage minority groups, session rooms).

Local funding

Engagement to set up and support referral and awareness raising

Time to seek support and participate in intervention

Motivation to participate in intervention

Activities

Programme mgmt.

Digital infrastructure development

Communication and awareness raising

Evaluation and monitoring to inform ongoing improvement

Establish referral pathways and make referrals

Complete triaging information

Attend initial assessment

Attend five weekly sessions (remote or f2f) plus optional sixth

Complete end of programme questionnaire

Outputs

Local Minds delivering service

Evaluation report

Appropriate referral pathways created

Awareness of programme and how to refer to it

Uptake of relevant support among priority audiences.

Number of sessions attended and tools completed

Onward referrals made

Satisfaction with quality of support provided (feel listened to; holistic support)

Short-term outcomes (end of 6-week intervention)

Improved reach and engagement among priority audiences

Reduced A&E / repeat GP attendances for people with mild to moderate MH needs

Reduced waiting lists / waiting times for Talking Therapies (specifically from the priority audiences)

Improved depression, anxiety, wellbeing, general health state

Improved motivation and ability to access to timely support (for onward referral and ongoing support)

Improved understanding of tools and approaches to support mental health

Long-term outcomes

Established evidence base of cost effectiveness of intervention

Programme consistently adopted across the Federation

SSH is embedded within wider mental health support offer

Reduced demand for high intensity interventions (through additional pathways/ more prevention)

Reduced inequalities in access to support

Improved long-term depression, anxiety, wellbeing and resilience

Reduced sickness absence

Impacts

Service commissioned by local systems

Reduced prevalence of clinical depression and anxiety

Reduced health service costs

Improved economic productivity

Reduced stigma for mental health problems and mental health support services

Our standards and accreditations

Ipsos' standards and accreditations provide our clients with the peace of mind that they can always depend on us to deliver reliable, sustainable findings. Our focus on quality and continuous improvement means we have embedded a "right first time" approach throughout our organisation.

ISO 20252

This is the international specific standard for market, opinion and social research, including insights and data analytics. Ipsos UK was the first company in the world to gain this accreditation.

Market Research Society (MRS) Company Partnership

By being an MRS Company Partner, Ipsos UK endorse and support the core MRS brand values of professionalism, research excellence and business effectiveness, and commit to comply with the MRS Code of Conduct throughout the organisation & we were the first company to sign our organisation up to the requirements & self-regulation of the MRS Code; more than 350 companies have followed our lead.

ISO 9001

International general company standard with a focus on continual improvement through quality management systems. In 1994 we became one of the early adopters of the ISO 9001 business standard.

ISO 27001

International standard for information security designed to ensure the selection of adequate and proportionate security controls. Ipsos UK was the first research company in the UK to be awarded this in August 2008.

The UK General Data Protection Regulation (UK GDPR) and the UK Data Protection Act 2018 (DPA)

Ipsos UK is required to comply with the UK General Data Protection Regulation (GDPR) and the UK Data Protection Act (DPA). These cover the processing of personal data and the protection of privacy.

HMG Cyber Essentials

Cyber Essentials defines a set of controls which, when properly implemented, provide organisations with basic protection from the most prevalent forms of threat coming from the internet. This is a government-backed, key deliverable of the UK's National Cyber Security Programme. Ipsos UK was assessed and validated for certification in 2016.

Fair Data

Ipsos UK is signed up as a "Fair Data" company by agreeing to adhere to twelve core principles. The principles support and complement other standards such as ISOs, and the requirements of data protection legislation. .

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