

# Factors affecting prevalence of mental health conditions in the UK: A relational perspective



## Contents

Recommendations and Summary .....	2
Recommendations .....	2
The real impact of long waiting lists .....	5
Why we need more relational support pathways.....	8
Medicalisation as a barrier to support.....	14
Why the stepped care model negatively impacts efficacy .....	17
Failing forward and the potential impacts of increasing digitalisation .....	19
References .....	22

## Recommendations and Summary

### Recommendations

1. The NHS should systematically collect data on private practice and third sector therapeutic provision, in collaboration with counselling and psychotherapy professional bodies, in order to build an accurate picture of population-level need and how it is being met.
2. The review should consider the data on those who disengage from NHS Talking Therapies: not only how many disengage, but why, and where they go next. That data would reveal a great deal about the shape of unmet need that current reporting obscures.
3. Commissioning frameworks should reflect the evidence on modality equivalence. The privileging of CBT in NHS provision is not supported by routine outcome data, and a system designed around genuine therapeutic choice and modality diversity would better serve the full range of people seeking support.
4. The existing social prescribing infrastructure should be examined for its potential to support more systematic integration of counselling and psychotherapy into NHS referral pathways, enabling people to access skilled relational support without requiring a clinical diagnosis as a gateway.
5. Any expansion of digital and AI-mediated mental health provision should be accompanied by rigorous, independent, longitudinal evaluation of outcomes, especially for marginalised populations, before being scaled, and should not be permitted to substitute for human therapeutic relationships where those relationships are what people need and want.

### About this submission

The NCPS is not commenting on any increase, perceived or actual, in diagnosis. Counsellors and psychotherapists are not diagnosticians, and while they frequently support people who have received a formal diagnosis of a mental health condition or neurodivergence, it is neither the intent of the profession nor within its scope of practice to diagnose. What we offer in this submission is an evidence-based, practitioner-level perspective on the structural and systemic factors that we believe are contributing to

rising prevalence: a perspective borne from the daily clinical experience of thousands of members working across the UK. Our conclusions are all drawn from systematically collected data, both from our own primary sources as well as from peer reviewed research.

Our central argument is this: rising prevalence does not only reflect an increase in the underlying burden of mental ill health. It also reflects a system that is structured in ways that delay access, narrow therapeutic choice, and leave large volumes of unmet and continuing need invisible to the data that shapes policy. The evidence we present across this submission points to several interlocking factors: long waiting times, medicalisation as a gatekeeping barrier, the limitations of the stepped care model, the underutilisation of the counselling and psychotherapy workforce, and the risks of accelerating digitalisation. Each of these factors contribute to that picture in distinct but related ways.

### What our members are telling us

Data from the [NCPS Annual Member Survey](#) provides an important contextual backdrop for this review. Respondents reported a marked increase in the complexity and intensity of presenting issues over the past twelve months. Anxiety remains the most commonly cited concern, with many practitioners noting a rise in acute and chronic symptoms linked to financial pressure, burnout, relationship difficulties, and uncertainty about the future. There has been a significant rise in clients identifying as neurodivergent (particularly with traits or diagnoses of ADHD and autism), many of whom are sat on long NHS waiting lists and looking for therapeutic support that statutory services are unable to provide.

Respondents also reported a notable increase in trauma-related presentations, including complex and relational trauma, dissociation, and post-pandemic distress. Broader social and political issues are increasingly entering the therapy room: clients are expressing heightened fear, anger, or hopelessness in response to global conflict, climate anxiety, and discrimination, particularly among LGBTQ+ and marginalised communities.

Many members highlighted that more men and young people are now accessing therapy, and that clients overall arrive more emotionally aware and willing to engage. However, the severity of issues and limited access to other services means clients are often presenting later, with more entrenched difficulties, than before.

The ongoing cost of living crisis was consistently identified as the most significant external factor affecting practice. Many practitioners noted that clients are increasingly unable to afford regular sessions, with some dropping to fortnightly appointments or

stopping altogether. What we're seeing is systemic hardship: when cost forces people out of private therapy and back onto statutory waiting lists, or simply out of support altogether, the burden falls on services that are already overstretched.

### The shape of the argument

Many of the people our members see are not presenting with neatly diagnosable conditions. They're bringing grief, relational trauma, life transitions, identity questions, and the accumulated weight and complexity of difficult circumstances. These experiences cause real and significant distress. The people our members see benefit substantially from skilled therapeutic support, but they don't always meet diagnostic thresholds, and in a system that uses diagnosis as a gateway to accessing support, that means many people either cannot access that support, or feel they don't deserve to ask for it.

The economic rationale for earlier, more accessible, non-medicalised support is made abundantly clear by the data. Picking people up further upstream, before difficulties become entrenched, before crisis services are needed, before employment and relationships and health deteriorate, is both clinically and economically sound. The counselling and psychotherapy workforce already operates as a de facto upstream service for the many people who can access it privately or through the voluntary sector.

The question this review should consider is why that workforce is not better integrated into the system that determines how mental health need is measured and met.

The sections that follow set out the evidence in detail.

We begin with the real impact of long waiting times, before turning to the parallel therapeutic ecosystem that is already absorbing unmet need; the role of medicalisation as a barrier to help-seeking; the structural limitations of the stepped care model; and finally the risks of a digitalisation trajectory that, if left unexamined, may deepen the very inequalities this review is trying to understand.

## The real impact of long waiting lists

Data from our [Annual Member Survey](#), alongside a growing body of independent research, points to long waiting times as a significant contributing factor to rising prevalence figures. Practitioners frequently report clients coming to them after unsuccessful attempts to access statutory services, or after prolonged delays that have allowed their difficulties to deepen, leading to a period during which distress can entrench, coping strategies can deteriorate, and the window for early, preventive intervention closes.

The data suggests several factors that may contribute to rising prevalence figures, as reflected in the experiences reported to practitioners by their clients.

Practitioners frequently report clients coming to them for counselling after unsuccessful attempts to access statutory services, or after experiencing delays in accessing therapy. An additional factor is that many people are presenting to these services with distress linked to life circumstances rather than diagnosable conditions, so expanding accessible, non-medicalised support pathways may help address distress earlier and potentially reduce the likelihood that they will escalate into more severe difficulties which then rely on more intensive and costlier crisis services.

[Research on young adults' experiences of mental health waiting lists](#) in the UK found that delays in treatment exacerbated existing mental and physical health symptoms, with participants reporting a range of consequences from increased distress to reliance on maladaptive coping strategies. Longer waits were also associated with greater drop-out and disengagement once treatment eventually began, reflecting reduced trust and motivation: outcomes that then further undermined recovery.

A [survey by Rethink Mental Illness](#) found that four in five people living with severe mental illness reported that their mental health deteriorated while waiting for treatment, with those affected describing mental health crises, suicide attempts, A&E attendances, contact with police, and job losses as direct consequences. [Clinical research using NHS data](#) has confirmed that longer waiting times are significantly associated with deterioration in patient outcomes, with the risk of clinically significant deterioration elevated for those waiting between three and twelve months, suggesting that delay both actively impedes recovery, as well as postponing it.

Official NHS reporting presents a broadly reassuring picture: the majority of people referred to NHS Talking Therapies receive an initial appointment within six weeks. Further analysis, however, shows that the average wait between first and second sessions (the point at which treatment actually begins) averages 62.5 days. [Research by](#)

[the Royal College of Psychiatrists](#) found that nearly two-thirds of patients on a hidden waiting list wait more than four weeks between their initial assessment and second appointment, with one in four waiting more than three months and one in nine waiting longer than six months. The six-week access standard, measured only against the first appointment, creates a misleading picture of service performance that shapes commissioning decisions without reflecting clinical reality. This review should consider the full patient journey, not just its first step.

The same research found that more than three-quarters of those on hidden waiting lists reported being forced to resort to emergency services or crisis lines in the absence of ongoing support, including A&E attendance, 999 calls, and crisis line contact. The downstream costs of under-resourcing timely therapy - in crisis service demand, A&E attendance, lost employment, and worsening complexity - are almost certainly greater than the cost of the therapy that was not provided. National analyses have also highlighted gaps in routine data reporting, particularly for people who disengage before attending multiple appointments, further limiting the visibility of unmet need within existing services.

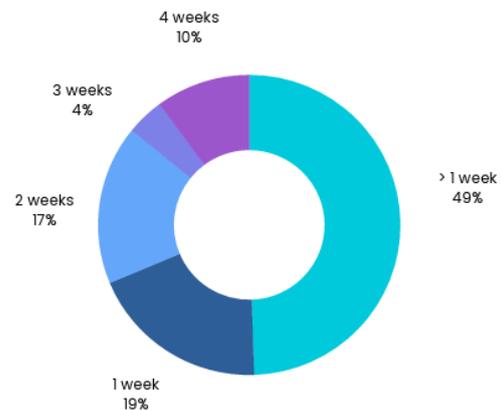
There is also [research that shows](#) clearly the impact that long waiting times have, especially on children and young people, with worsening symptoms, an increase in distress, and more reliance on alternative support while waiting.

Delays in giving people the therapy they need has real world consequences – [one study](#) found that shorter waiting times were associated with better employment outcomes and reduced time off work.

Research commissioned by the NHS examining barriers to NHS Talking Therapies, [which you can read here](#), also found high levels of non-attendance in some services, with a substantial proportion of referrals not attending their first appointment. Factors contributing to this include waiting times, expectations about therapy, and mismatches between the support offered and the needs of the person accessing therapy.

Alongside statutory provision, there is a large workforce of counsellors and psychotherapists already providing a parallel therapeutic ecosystem for those who can afford this, or access them through the voluntary sector (more detail on this in the following sections). A system that can better leverage this workforce is one worth seriously considering in any review. Data from the [NCPS Annual Member Survey](#) illustrates the scale of this.

### What are your current waiting times for Private Practice Work?



To give some idea of how long people have to wait to see a counsellor, 49% of respondents to the [NCPS annual survey](#) reported their typical waiting time for new clients is under one week. 19% have roughly a 1-week wait. 17% reported about a two-week wait, and 4% have around a three-week wait. The remaining 10% have four or more weeks wait on average for new private clients. This indicates that a majority (roughly 85%) of practitioners can schedule new clients within two weeks, though a notable minority have longer than a month wait times.

The waiting time contrast between the counselling and psychotherapy workforce and NHS Talking Therapies is striking. This is not a small or peripheral workforce, either: it is a large, accessible, and responsive one that is currently functioning as both a pressure valve and a continuation service for statutory provision. A system that could better integrate and leverage this workforce would be better placed to meet demand earlier, reduce the clinical harm of waiting, and address the rising prevalence that delayed access helps to sustain.

However, waiting time alone is not the only factor influencing outcomes. Equally important is whether people are able to access the type of therapy that best meets their needs – an issue is explored in the following section.

## Why we need more relational support pathways

A large system of relational therapeutic support already exists within the UK's mental health landscape. It operates largely outside formal NHS structures, is not captured in national datasets, and is already absorbing significant demand that statutory services cannot meet. Understanding how this workforce functions, and why it functions differently, is essential to any serious analysis of mental health prevalence.

Relational therapy refers to an approach in which the therapeutic relationship itself is the primary mechanism of change. Rather than focusing solely on structured techniques or protocols, relational approaches (which include person-centred, humanistic, psychodynamic, integrative, and many other modalities) emphasise collaboration, attunement, and responsiveness. Research into psychotherapy outcomes consistently identifies the quality of the therapeutic relationship, client motivation, and the degree to which people feel genuinely engaged with the therapeutic process as among the strongest predictors of positive outcomes across different approaches.

This points toward what researchers have termed the "common factors" of effective therapy: the relational conditions, being alliance, empathy, collaboration, and genuine engagement that appear to drive outcomes across different therapeutic modalities. It suggests that restricting access to a single branded modality, however well-researched in controlled trials, may not be justified by what actually determines whether therapy works in practice.

In terms of prevalence, a system that offers only one or two therapeutic modalities, delivered in fixed, time-limited formats, simply will not engage everyone who needs support. People who do not connect with a particular approach, or who do not feel that the service reflects the nature of their difficulties, are more likely to disengage – or never to engage in the first place. The result of all this is unmet need that does not disappear but instead exacerbates, and that will surface later in crisis or more entrenched form.

The NHS's near-exclusive reliance on CBT as its psychological therapy of choice reflects a policy preference shaped partly by the availability of RCT evidence, and by NICE's methodology for evaluating that evidence. What it does *not* reflect is superiority in routine clinical practice.

[Two studies by Stiles, Barkham and colleagues](#) examined outcomes for patients receiving CBT, person-centred therapy, and psychodynamic therapy across NHS primary care settings in the UK, using the Clinical Outcomes in Routine Evaluation measure (CORE-OM). In a replication study of over 5,600 patients across 32 NHS

services, all three therapeutic approaches produced marked improvement, with an overall pre/post effect size of 1.39, and neither treatment approach nor the degree to which it was delivered in pure versus combined form had a statistically significant effect on outcomes.

[The earlier study](#), drawing on 1,309 patients across 58 NHS sites, found the same pattern: treatment approach and degree of purity each accounted for statistically significant but comparatively tiny proportions of variance in outcomes: respectively 1% and 0.5% as much as pre/post change.

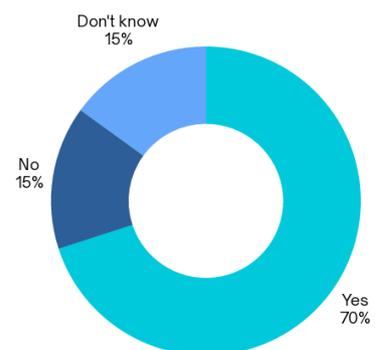
There's a direct policy implication here: the NHS's own routine outcome data does not support the privileging of CBT over other therapeutic approaches. Researchers have described this as "psychotherapy's equivalence paradox": the consistent finding that theoretically different approaches tend to produce equivalent positive outcomes, suggesting that common relational factors may underlie therapeutic success across modalities.

A system that funds and commissions primarily one modality is not doing so on the basis of outcome data from routine practice; it is doing so on the basis of a research methodology that systematically advantages structured, manualised treatments over relational ones.

Many people in the UK access relational therapies through private practice, third sector services, or informal referral pathways such as social prescribing. Data from the [NCPS Annual Member Survey](#) provides a direct window into how this parallel system is functioning.

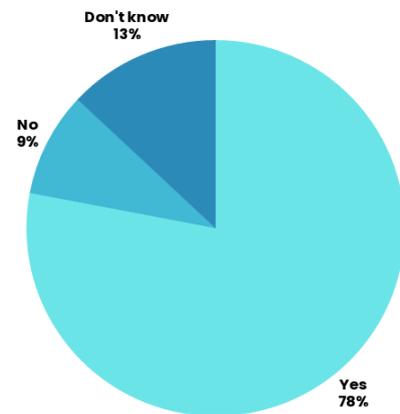
When asked whether they had seen clients who had tried to access support through the NHS but ended up in private therapy due to waiting times, 70% of respondents confirmed that they had. This is not a marginal phenomenon: it represents the majority of a large professional workforce reporting that they are routinely receiving clients who could not get timely NHS help.

**Have you seen private clients that were trying to access support via the NHS but ended up accessing private therapy due to NHS Wait times?**



Even more striking is the picture of what happens after statutory treatment. When asked whether they had seen clients who had been through NHS Talking Therapies but still needed further support, 78% of respondents said yes. Nearly four in five. Only 9% said they had not.

**Have you seen clients who have accessed NHS Talking Therapies and attended therapy, but felt they needed further support from private therapy?**

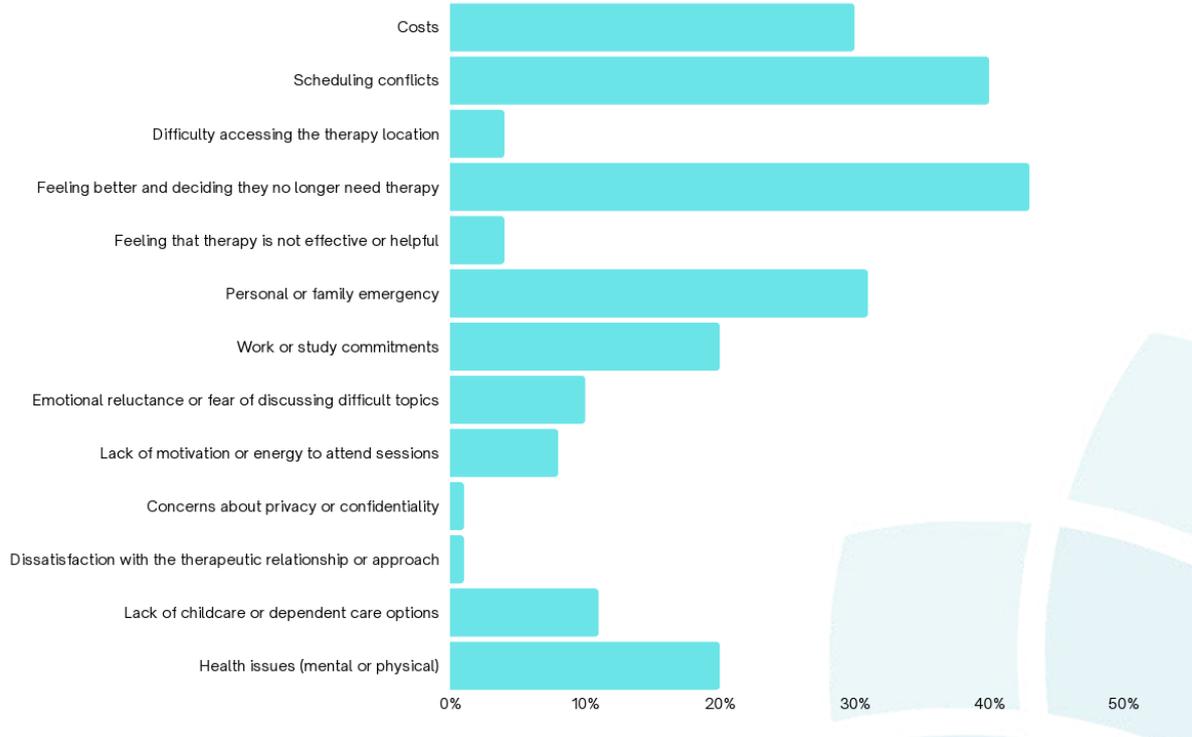


This figure deserves particular attention from this review. It suggests that for a very substantial proportion of clients, completing a course of NHS Talking Therapies does not represent the end of their need; it represents a handover to a workforce that sits outside national data collection entirely. If the NHS is not systematically tracking what happens to people after they leave its services, and if the private and third sector practitioners who see those people next are not included in national reporting, then prevalence data will structurally undercount ongoing and unresolved need.

Taken together, these findings indicate that counselling and psychotherapy services outside the NHS are functioning simultaneously as an alternative for those who cannot access timely statutory care, and as a continuation for those who complete NHS treatment but are not yet well. This is a significant and largely invisible role. Access to it, however, is profoundly unequal: it depends almost entirely on the ability to pay.

The NCPS survey also asked practitioners about the most common reasons their clients give for cancelling sessions or not attending.

**What are the most common reasons your clients or potential clients give for cancelling therapy or non-attendance?**



The most frequently reported reason, cited by 43% of respondents, was clients feeling better and deciding they no longer need therapy. Only 4% cited therapy being ineffective or unhelpful as a reason. The overwhelming reason people stop private counselling is that it has worked, not that it has failed. The picture in statutory services, where non-completion and non-recovery rates are substantially higher, is very different.

Cost was reported as a significant factor by 30% of practitioners, which is a figure that speaks directly to the equity issue. Private therapy, it appears, suffers from the inverse of the problem that affects statutory provision: people feel it works for them, but many cannot afford to continue.

A system capable of extending access to this kind of support, either through the voluntary sector, social prescribing, or better integration of the counselling workforce into NHS pathways, would be better placed to meet need earlier and more equitably.

The infrastructure for integrating a broader, non-medicalised therapeutic workforce into NHS care does already exist in some form. Social prescribing is already an established part of the NHS Long Term Plan, with link workers now embedded across primary care networks in England. There is robust evidence supporting the efficacy of social prescribing for mental health, including for loneliness, stress, mild to moderate depression, and anxiety, as well as strong and [growing evidence](#) that social prescribing

services can lead to substantial reductions in avoidable GP appointments, hospital admissions, and A&E attendances.

A [systematic review of service users' experiences of social prescribing for mental health](#) found that person-centred care was identified as the central factor in effective delivery, with positive outcomes attributed to trusting relationships with link workers and a supportive environment that enabled people to explore their difficulties.

In other words, what makes social prescribing work, where it does work, is the same relational mechanism that drives effective counselling and psychotherapy. The principle is already accepted; the question is whether it can be applied at greater scale and with greater clinical depth.

It is important to note that the evidence base for social prescribing remains methodologically mixed, and further rigorous evaluation is needed before strong conclusions can be drawn about its effectiveness across all populations and presentations. The point here is not that social prescribing is a substitute for skilled therapeutic intervention, but that it demonstrates a functioning model for connecting people to non-medicalised support through NHS infrastructure: a model that could, with appropriate investment and integration, encompass the counselling and psychotherapy workforce more fully.

Systems that give people genuine choice over both the type of therapy they receive and the practitioner they work with are associated with stronger engagement and better outcomes. [Research confirms](#) that patients who are not matched to their preferred treatment are significantly more likely to drop out of therapy, which is an effect comparable in size to other optimisation strategies such as personalisation and progress monitoring. Therapeutic fit is a clinical variable, yet we seem to view it societally as a luxury only available to those who can afford it.

The Stiles equivalence evidence reinforces this point from a different angle. If outcomes across modalities are broadly equivalent in routine practice, then the case for restricting access to a single approach rests on something other than clinical outcomes, and what it rests on, in practice, is administrative convenience and commissioning inertia. A system redesigned around genuine choice and modality diversity would not be sacrificing clinical standards; it would be meeting them in a way that reaches more people.

Counselling and psychotherapy outside statutory services are naturally more diverse in the approaches they offer: practitioners work across a wide range of modalities, allowing clients to access different ways of working depending on their needs, preferences, and goals. This diversity, which includes integrative, person-centred, humanistic, psychodynamic, solution-focused, trauma-informed, and many other approaches, is an asset that the current system is not designed to make use of. Within

statutory services, pathways to support are structured around diagnostic frameworks and predefined treatment models, which means that people whose distress does not map neatly onto those frameworks may struggle to access support that works for them, or may not feel eligible for support at all.

At present, the NHS does not routinely collect data from private practitioners or third sector counselling services, nor does it systematically collaborate with professional bodies to do so. This means that the parallel therapeutic ecosystem described above, which is, as the survey data shows, already absorbing a large proportion of unmet and continuing need, is functionally invisible to national prevalence and outcomes reporting. It has become a structural blind spot that distorts the picture of how mental health need is being met in the UK, makes the NHS appear more self-contained than it is, and it makes prevalence appear lower than it is, because a substantial portion of ongoing need is being managed outside the systems that generate the data.

The NCPS, working with the [Partnership of Counselling and Psychotherapy Bodies \(PCPB\)](#), could look to collaborate with the NHS in contributing practitioner-level data to help build a more accurate picture of this wider therapeutic ecosystem. We would welcome engagement with NHS England and the review team on how to make this possible.

Within statutory services, pathways to support are often structured around diagnostic frameworks and predefined treatment models. This raises important questions about the role that medicalisation plays in shaping access to psychological support: questions we explore in the following section.

## Medicalisation as a barrier to support

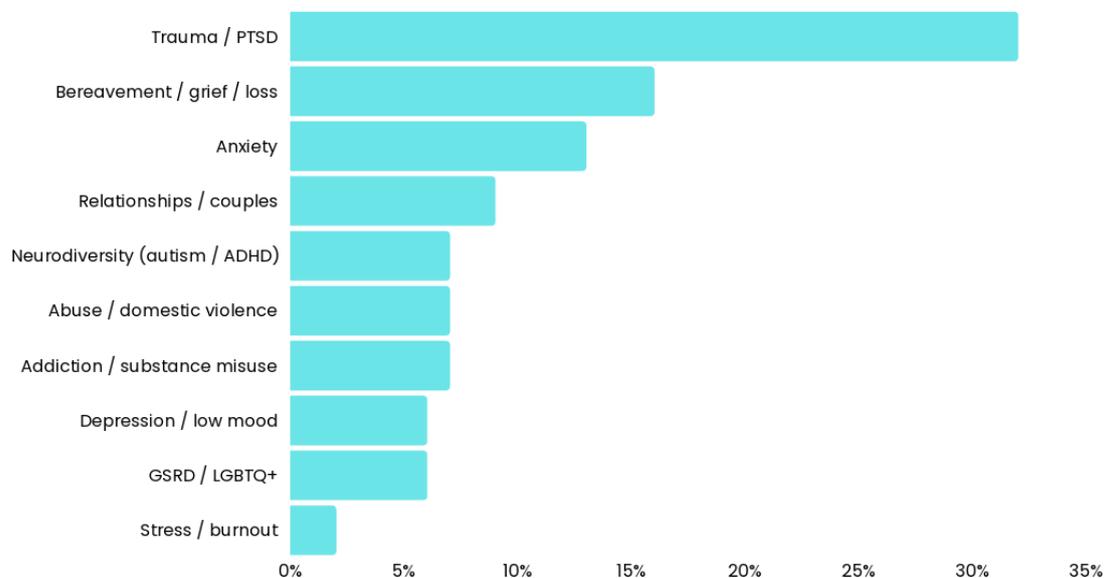
Counselling and psychotherapy services frequently work with people who are experiencing challenges such as relationship difficulties, bereavement, trauma, financial stress, workplace pressures, or major life transitions. While these experiences can cause significant emotional distress, they may not always align neatly with diagnostic frameworks, or sit within a medical model of therapy. What this means in practice is that people can feel they need to frame their experiences in clinical terms in order to access support - and for many, that requirement is itself a barrier to seeking help at all.

The research on help-seeking behaviour is consistent on this point. [A systematic review of patients' perspectives on accessing support for common mental health problems in England](#) found that stigma and people's understandings of their own difficulties significantly shaped their help-seeking decisions, with primary care frequently not perceived as a place where mental health difficulties would be prioritised or effectively supported. This deterrent effect is not evenly distributed across the population. A [UK study of young adults](#) found that 35% of those experiencing emotional or mental health difficulties did not seek any formal or informal help, with stigmatising beliefs, difficulty identifying or expressing concerns, and a preference for self-reliance among the most prominent barriers. For men, the picture is particularly stark: [research consistently identifies](#) that difficulties communicating distress, fear of shame, and traditional masculine norms around emotional self-sufficiency combine to make formal help-seeking especially unlikely, with young men frequently becoming avoidant rather than disclosing difficulties.

The barriers are compounded further for people from racially minoritised communities. [A meta-ethnography of ethnic inequalities in UK mental healthcare](#) found that the perceived dominance of a biomedical and Eurocentric model was a powerful barrier that cut across access, experience, and outcomes with the current system experienced as designed for people from white British backgrounds, reducing individuals to labels and symptoms while excluding social, racial, religious, and cultural dimensions of their distress. There are [well-documented cross-cultural differences](#) in how depression and distress present, including somatic symptoms as cultural expressions of difficulty, which may not match Western diagnostic criteria, leading to under-diagnosis or misdiagnosis for people from diverse backgrounds. Taken together, these findings suggest that a system structured around diagnostic gatekeeping does not simply fail to reach some people, but it actively excludes them.

This has real consequences for prevalence. When people do not feel they qualify for support, or when the available support does not reflect the nature of their distress, they are likely to delay help-seeking until difficulties become more entrenched. [Research with Black and minority ethnic communities in the UK](#) found that delayed help-seeking and crisis presentation were common outcomes of stigma and non-recognition of distress, with people presenting only when difficulties had become very severe. The medicalisation of access is not a neutral administrative feature of the system; it's a mechanism that compounds unmet need and, over time, contributes to rising prevalence.

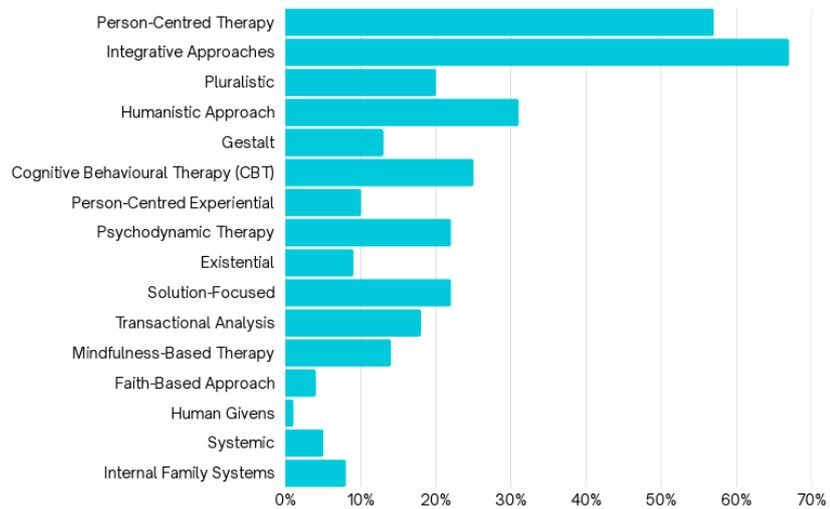
Data from the [NCPS Annual Member Survey](#) provides some insight into the types of issues that counsellors and psychotherapists are commonly supporting clients with, and illustrates the contrast between what people are actually bringing to counsellors and what a diagnostic framework would recognise.



According to respondents, their most common areas of specialisation were Trauma / PTSD (32%), Bereavement/Grief (16%), and Anxiety (13%). Many listed Depression (6%) and Addiction (7%). Specialisation in relationships/couples work was noted frequently as well (9%). Gender, Sexuality and Relationship Diversity (LGBT+/GSRD) was mentioned by around 6% respondents, and neurodivergent clients (autism, ADHD) by 7%, while Abuse/Domestic violence is a specialism of 7% of respondents.

Many of these presentations (grief, relational trauma, life transitions, identity) do not map neatly onto diagnostic categories, yet they represent significant human distress that benefits substantially from skilled therapeutic support.

**Which modality /  
modalities best describes  
your practice?**



The breadth of modalities used by NCPS members reflects precisely the flexibility that a medicalised system cannot easily accommodate. An integrative approach was the most widely used, with 67% of respondents drawing on multiple frameworks to work in the way best suited to the individual client. Person-centred therapy (57%), humanistic approaches (31%), psychodynamic therapy (22%), and solution-focused therapy (22%) were also widely represented, alongside CBT (25%) and a wide range of specialist approaches including EMDR, schema therapy, compassion-focused therapy, somatic therapies, and many others. While the NHS mainly offers CBT to any meaningful extent, with counsellors making up only approximately 6% of the workforce and psychotherapists around 2%, the counselling and psychotherapy workforce offers a genuinely pluralistic range of approaches, often including CBT alongside relational, humanistic, and trauma-informed modalities.

A system that offers one primary modality, particularly one that asks people to present their issues in clinical terms, will systematically fail to attract and retain the people who most need early support but who do not identify with a medical model of their distress. Expanding access to non-medicalised, relationally-oriented, modality-diverse provision is therefore both a question of workforce efficiency *and* equity.

For those who do manage to access statutory services, the barriers do not end at the door. The structure of the system they enter can itself become an obstacle to effective support. NHS Talking Therapies operates a stepped-care model that, whatever its intentions, creates a further set of structural mismatches between what people need and what they receive. Mismatches that, like medicalisation, fall disproportionately on those with the most complex presentations.

## Why the stepped care model negatively impacts efficacy

The NHS Talking Therapies model has typically relied on a stepped-care approach, where patients (as per NHS parlance) begin with low-intensity interventions (often guided self-help or CBT) and are then 'stepped up' to high-intensity therapy if initial treatments are unsuccessful.

In practice, this often involves switching therapist, undergoing new assessments, and enduring further waiting lists. These transitions disrupt continuity, rupture therapeutic relationships, and delay effective treatment.

The harms of this sequential structure are increasingly well-documented. [Research by Delgadillo and colleagues](#) suggests two particular mechanisms by which the stepped-care model disadvantages complex cases: first, demoralisation (patients may become demoralised after accessing an inadequately brief intervention for their needs, reducing their expectations of improvement and thereby undermining subsequent treatment); and second, continued deterioration (patients who do not improve during the preliminary low-intensity step may become more severely impaired by the time they access higher-intensity care). In this way, the model's apparent efficiency conceals a clinical cost that falls disproportionately on those with the greatest need. There is also a significant body of evidence questioning whether the stepped-care model effectively identifies who should receive high-intensity treatment and when.

Evidence of the effectiveness of stepped care as a service delivery model is limited, particularly when comparisons between stratified and progressive models are sought; implementation varies across services, and clinician bias has been shown to affect pathway flow, which has been demonstrated in [this 2019 study](#).

Adding to this, [qualitative evidence](#) suggests that stepping-up decisions do not occur consistently, nor always congruently with clinical guidelines, with therapists frequently holding non-improving patients in treatment rather than referring them onward. The efficiency premise upon which the model rests is therefore not reliably realised in practice.

The evidence increasingly favours approaches that match treatment intensity to presenting complexity from the outset, rather than subjecting patients to sequential failure. [A cluster randomised clinical trial](#) found that *stratified* care, in which patients were matched to either low- or high-intensity treatment at initial assessment using a multifactorial algorithm, produced significantly higher rates of reliable and clinically significant improvement than stepped care.

These limitations are compounded at a population level by the scale of non-completion and non-recovery within NHS Talking Therapies. [National data indicate](#) that of 1,647,716 IAPT referrals in 2019/20, 63.21% did not complete treatment, and of those who did complete, approximately 60% did not achieve clinical recovery.

Complex relational difficulties, which are neither systematically detected nor addressed within the NHS Talking Therapies framework, are thought to contribute significantly to this treatment resistance, confounding outcomes for both depression and anxiety.

The therapeutic relationship is central to understanding this. There is [a substantial amount of literature](#) that confirms the quality of the alliance between client and therapist is one of the most robust predictors of outcome across all modalities. Multiple meta-analyses have consistently found fairly stable, positive correlations between therapeutic alliance and treatment outcome.

The emerging picture, then, is that the quality of the client–therapist alliance is a reliable predictor of positive clinical outcome, independent of the variety of psychotherapy approach or outcome measure used.

When a patient is required to transition between practitioners, as the stepped-care model routinely demands, any accumulated alliance must be abandoned and rebuilt, at cost to the client and to the work.

The stepped-care model also fails to account for the importance of client preference. [A systematic review and meta-analysis](#) found that patients who were not offered a choice or matched to their preferred treatment were 1.46 times more likely to drop out of therapy; the effect sizes associated with preference matching were comparable to those found for other optimisation strategies, including personalisation and progress feedback. A model that sequentially assigns patients to low-intensity treatments regardless of preference or complexity is structurally misaligned with this evidence.

In contrast, counsellors and psychotherapists are trained to work flexibly across a spectrum of intensity: from brief, focused support to longer-term, in-depth therapy. In all cases, the relational is the fundamental underpinning of that work. Rather than funnelling clients through rigid tiers of provision, counselling offers a more seamless model wherein the same practitioner can scale the intensity of support up or down as needed, guided by the therapeutic relationship and the client's changing circumstances or preferences, which also contributes to improved outcomes. The NHS's reliance on a single modality (predominantly CBT) delivered through stepped-care tiers misses the opportunities the counselling and psychotherapy workforce can offer. Counselling can deliver both low and high-intensity care within one relational framework, thereby combining the accessibility of early support with the depth needed for more complex presentations.

## Failing forward and the potential impacts of increasing digitalisation

The prevalence review is primarily concerned with the present picture, but any recommendations that emerge from this process will shape service design for years to come. It would therefore be a significant omission not to address a development that is already underway and whose long-term consequences for mental health prevalence have not yet been adequately measured: the accelerating digitalisation of mental health services, and in particular the growing deployment of AI chatbots as a frontline mental health intervention.

The NCPS does not oppose digital innovation in principle. But the evidence increasingly points to a set of risks that, if left unaddressed, could actively worsen the prevalence of mental health conditions over the long term, particularly among the young, the marginalised, and the most isolated.

The first and most immediate concern is one of data. When a person disengages from a human therapist, there is typically a clinical record: a discharge, a non-attendance, a referral onward. When a person disengages from a chatbot because they did not feel heard, did not trust the medium, or simply did not want to speak to a machine, that disengagement is generally invisible.

[NCPS-commissioned YouGov data](#) confirms that a significant proportion of people don't want to access mental health support via a chatbot: they want to speak to a human being. If those people disengage without saying anything, look for help elsewhere, or simply go without support, the system will not capture them. The third sector and private counsellors will absorb some of this unmet need, as they already do with NHS waiting list overflow, but those who can't afford private support will likely go without.

The result will be another hidden and growing gap between measured service activity and actual population need: exactly the kind of distortion that makes prevalence data unreliable, and that makes the case for expanding digital provision look stronger than it actually is.

The second concern is more insidious and potentially more damaging over time. When chatbots are designed with human-like conversational styles or anthropomorphic features, users are more likely to perceive them as empathetic and caring, even though no genuine empathy is present. [Research demonstrates](#) that such design features reduce psychological distance and increase trust and compliance with recommendations. More troublingly, [recent work on what has been termed the "illusion of empathy"](#) shows that conversational agents can strategically shape users' perception

of empathy, leading them to systematically overestimate the relational capacity of the system.

This effect is of particular concern for children and young people. In contexts of loneliness or limited social support, young people are especially likely to anthropomorphise chatbots: to believe the system genuinely understands or cares about them. [Evidence from studies of social chatbot use](#) (such as Replika) shows that loneliness, trust, and personification drive progressively deeper attachment, which can displace or interfere with human relationships. In some documented cases, users have become convinced their chatbot is sentient, with serious consequences for their mental health. [Paediatric experts have cautioned](#) that companion chatbots can cultivate illusory empathy and misplaced trust in children and young people, potentially displacing help-seeking from human professionals and impairing social development; several reports now recommend against their use with under-18s altogether.

The danger is cumulative. Because the empathy offered by a chatbot is simulated rather than genuinely attuned, it provides only shallow support, and over time may actively erode the social and relational capacities that counselling and psychotherapy work to develop and restore. Users who come to [believe that chatbot interaction is sufficient may disengage from the human therapeutic relationships that could actually help them](#), while also reducing their capacity for the kinds of genuine human connection that protect against mental ill health in the first place. Far from reducing prevalence, this trajectory actually risks deepening it.

The third concern we have is structural. AI mental health tools are typically trained on datasets that do not adequately represent the diversity of the populations they will serve. [Research has shown](#) that such tools can generate measurably different responses based on the perceived race or gender of the user, with GPT-4's empathetic responses found to be lower for Black and Asian users than for white users, and [empathy expression varying significantly by perceived user gender](#). A [review of AI chatbots in mental health contexts](#) warns that algorithmic bias in training data may result in people from ethnic minority, low-income, or linguistically diverse backgrounds receiving inaccurate or harmful advice.

Cultural validity presents an additional and underappreciated risk. Emotional expression, idioms of distress, and symptom presentation vary significantly across cultures; what presents as one condition in a Western clinical context may present very differently elsewhere. AI systems that fail to account for this [risk misdiagnosis, under-recognition, or inappropriate clinical guidance](#) across large portions of the population.

Across the field, [patient safety, equity, and long-term outcomes are rarely evaluated](#) in mental health app research, meaning that [the consequences for underserved groups are likely to remain masked](#) until the harm is already done.

Finally, and perhaps most fundamentally, the shift towards digital and AI-mediated support risks removing entirely the embodied, relational dimension of therapy that the evidence base consistently identifies as its most active ingredient.

Skilled therapists attend not only to what clients say, but to how they say it: to silence, micro-expressions, posture, breathing, and the subtle incongruences between verbal and non-verbal communication that often reveal what words conceal. [Research on embodied synchrony](#) shows that client–therapist bodily coordination (movement mirroring, postural alignment) is associated with stronger rapport and better outcomes, and the field of embodied cognition increasingly suggests that [mental health is deeply tied to what the body expresses and senses in relational interaction](#), not merely to the content of verbal exchange. No chatbot, however sophisticated, can replicate this dimension of the therapeutic encounter.

Taken together, these concerns point in a consistent direction: a mental health system that increasingly substitutes digital tools for human therapeutic relationships is not simply a more efficient version of the existing system. It is a qualitatively different system, one that is likely to produce invisibly worse outcomes, to serve marginalised populations less fairly, and to erode the very relational capacities that protect against mental ill health in the broader population. The review should consider not only what digital provision can measure, but what it cannot, and who will be left behind when the data does not capture them.

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