The Improving Access to Psychological Therapies Manual

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Foreword

Depression and anxiety disorders can have a devastating effect on individuals, their families and society. Thankfully, considerable progress has been made in developing effective psychological therapies for these conditions. This progress has been recognised by the National Institute for Health and Care Excellence (NICE) which now recommends particular psychological therapies as first choice interventions for depression and anxiety disorders. However, in most countries few members of the public benefit from these advances as there are insufficient appropriately trained therapists. England is an exception. Starting in 2008, the NHS has trained and employed an increasing number of clinicians who work in Improving Access to Psychological Therapies (IAPT) services. Individuals who are seen within those services can expect to receive a course of NICE-recommended psychological therapy from an appropriately trained individual and to have their clinical outcomes monitored and reported.

From small beginnings, the IAPT programme has grown so that it now sees around 900,000 people a year. Over 550,000 go on to have a course of psychological therapy. The others receive an assessment, advice and signposting (if appropriate). A unique outcome monitoring system ensures over 98% of treated individuals have their depression and anxiety assessed at the beginning and end of treatment. One might expect some attenuation of clinical outcomes when treatments are implemented outside the artificial environment of a clinical trial. However, IAPT set itself the ambitious target of achieving similar results. Specifically, a minimum of 50% recovery for all individuals completing treatment. Initially, this was an elusive target but it was finally achieved in January 2017. Currently approximately one in two people who have a course of treatment in IAPT recover and two out of three people show worthwhile improvements in their mental health. The effort to secure such impressive outcomes has generated very substantial learning which this document aims to share nationally and internationally.

The success of the IAPT programme has been recognised and the NHS has committed to further expanding IAPT services so 1.5 million people per year will be seen by 2020/21. This represents around a quarter of the community prevalence of depression and anxiety disorders.

The IAPT Manual has been written to help commissioners, managers and clinicians expand their local IAPT services while maintaining quality and ensuring that patients receive effective and compassionately delivered care. To produce the manual, the team at the National Collaborating Centre for Mental Health have carefully considered the research literature and have also drawn on the accumulated wisdom of numerous clinicians and commissioners who have worked hard to make IAPT the success it is today. Readers will find invaluable guidance on setting up and running an efficient IAPT service that achieves good outcomes with the individuals who receive a course of treatment and creates an innovative and supportive environment for staff as well as clients. IAPT is a work in progress. Much more can be learned about how to effectively deliver psychological therapies at scale. For this reason, the manual also provides guidance on how to use local and national data to better understand the strengths and limitations of a service, along with advice on developing and evaluating service innovation projects.
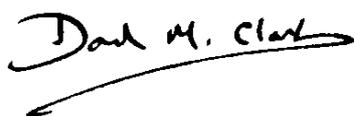
Professor David M Clark CBE
National Clinical and Informatics Adviser for IAPT

1 Introduction

The Improving Access to Psychological Therapies (IAPT) programme was developed as a systematic way to organise and improve the delivery of, and access to, evidence-based psychological therapies within the NHS. It had its roots in significant clinical and policy developments.

The success of two pilot projects established in 2006 led to the national implementation of the IAPT programme in 2008, which has since transformed the treatment of depression and anxiety disorders in adults in England. Over 950,000 people now access IAPT services each year. Among those who receive a course of treatment, approximately one in two recover and two in three show a reliable reduction in their symptoms.

[The Five Year Forward View for Mental Health](1)[1] set out a commitment to expanding IAPT services and improving quality further, with a view to increasing access to psychological therapies for an additional 600,000 people with common mental health problems each year by 2020/21. This will be achieved by recruiting and training an extra 4500 clinicians, 3000 of whom will be based in primary care.

1.1 Purpose and scope of this document

This manual is for all commissioners, providers and clinicians (including trainees) of services that deliver psychological therapies for depression and anxiety disorders in adults.[a] It serves as an essential manual for IAPT services, describing the IAPT model in detail and how to deliver it, with a focus on the importance of providing National Institute for Health and Care Excellence (NICE)-recommended care (see Section [3](#)). It also aims to support the further implementation and expansion of IAPT services.

This manual encompasses the following priorities for service development and delivery:
- Expanding services so that at least 1.5 million adults can access care each year by 2020/21
- Focusing on people with depression and/or any of the anxiety disorders. As IAPT services expand they are expected to increase access to treatment for people who also have long-term physical health conditions, by recruiting and deploying appropriately trained staff in IAPT services where psychological and physical treatment are co-located (these are called 'IAPT-LTC services' in this manual). Such services should also have a focus on people distressed by medically unexplained symptoms, to help this group of people achieve better outcomes
- Improving quality and people's experience of services. This includes improving the numbers of people who recover, reducing geographic variation between services and reducing inequalities in access and outcomes for particular population groups
- Supporting people to find or stay in work, so that IAPT services can better meet a person's individual employment needs and contribute to improved employment outcomes.

1.2 Navigating the manual

The document has been organised into 11 further chapters as set out in [Figure 1](#), which provides a brief overview of each chapter's content.

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[a] Information on children and young people's IAPT services can be found [here](#).

Figure 1

How to navigate the manual

Chapter 2
Conditions treated by IAPT services: describes each condition and the general impact of these conditions on the individual and society

Part 1: Context

Chapter 3
The importance of delivering evidence-based care: establishing the effectiveness of therapies and NICE-recommended therapies

Chapter 4
The IAPT workforce: ensuring competence, quality and staff retention

Part 2: The way IAPT works

Chapter 5
Delivering effective assessment and treatment

Chapter 6
The importance of data: monitoring clinical outcomes and activity

Chapter 7
Improving access

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Chapter 8
Reducing waiting times

Chapter 9
Improving recovery

Chapter 10
Improving equity of access and outcomes for all

Chapter 11
Working with the wider system

Chapter 12
Key features of a well commissioned IAPT service

Definitions of terms and abbreviations
References

Positive practice examples

Appendices and helpful resources

Appendices including further details on NICE-recommended care, competence frameworks and screening prompts

Copies of case identification tools and outcome measures

Links to helpful web-based resources

1.3 What IAPT is

IAPT services provide evidence-based treatments for people with depression and anxiety disorders, and comorbid long-term physical health conditions (LTCs) or medically unexplained symptoms (MUS) (when integrated with physical healthcare pathways[b]). IAPT services are characterised by three key principles:

- **Evidence-based psychological therapies at the appropriate dose**: where NICE-recommended therapies are matched to the mental health problem, and the intensity and duration of delivery is designed to optimise outcomes.
- **Appropriately trained and supervised workforce**: where high-quality care is provided by clinicians who are trained to an agreed level of competence and accredited in the specific therapies they deliver, and who receive weekly outcomes-focused supervision by senior clinical practitioners with the relevant competences who can support them to continuously improve.
- **Routine outcome monitoring** on a session-by-session basis, so that the person having therapy and the clinician offering it have up-to-date information on the person's progress. This helps guide the course of each person's treatment and provides a resource for service improvement, transparency and public accountability.

Services are delivered using a stepped-care model, which works according to the principle that people should be offered the least intrusive intervention appropriate for their needs first. Many people with mild to moderate depression or anxiety disorders are likely to benefit from a course of low-intensity treatment delivered by a psychological wellbeing practitioner (PWP). Individuals who do not fully recover at this level should be stepped up to a course of high-intensity treatment. NICE guidance recommends that people with more severe depression and those with social anxiety disorder or post-traumatic stress disorder (PTSD) should receive high-intensity interventions first.

1.3.1 Who IAPT is for

IAPT services provide support for adults with depression and anxiety disorders that can be managed effectively in a uni-professional context. NICE-recommended therapies are delivered by a single competent clinician, with or without concurrent pharmacological treatment which is typically managed by the GP, though there may be some circumstances when medication is managed within secondary care.

Core IAPT services provide treatment for people with the following common mental health problems (see Table 1):

- depression
- generalised anxiety disorder
- social anxiety disorder
- panic disorder
- agoraphobia
- obsessive-compulsive disorder (OCD)
- specific phobias (such as heights or small animals)
- PTSD
- health anxiety (hypochondriasis)
- body dysmorphic disorder mixed depression and anxiety (the term for sub-syndromal depression and anxiety, rather than both depression and anxiety).

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[b] See The Improving Access to Psychological Therapies (IAPT) Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms.

It is recognised that many people suffer from more than one of these conditions. In addition to evidence-based psychological therapies, IAPT services also provide employment support to people, where appropriate.

In line with the implementation of [The Five Year Forward View for Mental Health](#), evidence-based treatment will be extended to people with comorbid LTCs or MUS (See Section [11.2](#)). The newly developed IAPT-LTC services will focus on people who have LTCs in the context of depression and anxiety disorders and will also aim to treat the following conditions:

- irritable bowel syndrome
- chronic fatigue syndrome
- MUS not otherwise specified.

Drug and alcohol misuse are not automatic exclusion criteria for accessing IAPT if, following assessment, it is determined that the person would benefit from IAPT interventions in line with NICE guidance. However, IAPT does not provide complex interventions to treat drug and alcohol misuse. The level of drug or alcohol misuse should not interfere with the person's ability to attend and engage in therapy sessions. If this is not the case, NICE guidelines recommend treatment for drug or alcohol misuse first. This highlights the need for services to work together to develop locally agreed pathways and criteria for more specialist intervention when indicated. Please see the [IAPT Positive Practice Guide for Working with People who use Drugs and Alcohol](#).

A person's involvement with secondary mental health care services should not lead to automatic exclusion from IAPT services. In principle, the greater the complexity of the presenting issue, the more substantial and multi-professional the package of care needs to be. Where problems are less complex, uni-professional intervention, such as those delivered within IAPT services, may be the most appropriate, even if concurrent pharmacological treatment is provided by primary or secondary care services. However, for more complex problems, multi-professional interventions delivered by secondary mental health care services would usually be expected.

Adults with PTSD who have experienced multiple traumas should not be routinely excluded from IAPT services. Clinicians should assess case suitability taking into account risk assessment and the number of traumas that result in intrusive memories, rather than on the total number of traumatic events that a person has experienced. It is expected that many people with between 1 and 3 traumas that result in intrusive memories could be realistically treated in IAPT services.

1.3.2 IAPT service provision

IAPT services sit within a wider system of care and are commissioned by local clinical commissioning groups (CCGs). IAPT spans primary and secondary mental health care. It operates as a 'hub and spoke' model, which typically includes a central management and administration office with strong primary care and community links that enable most of the face-to-face therapy to be provided in local settings that are as easy for people to access as possible (such as GP practices, community settings and voluntary organisations). Referral pathways have been specifically developed to promote access and equality. They include:

- self-referral
- community or voluntary service referral
- primary care referral
- secondary care referral (including both mental health and physical health care services)

IAPT services need to develop strong relationships with professionals across a broad range of mental health care pathways, as well as social care, to ensure that people with needs that are either not appropriate or too complex for IAPT services receive the necessary care in the right place.

2 Conditions treated by IAPT services

2.1 Depression, anxiety disorders and other conditions covered by IAPT

Depression and anxiety disorders are the most common mental health problems affecting individuals (approximately 16% of the population at any one time), and society.[2] Table 1 provides a brief description of depression, the most common anxiety related disorders and other conditions treated within IAPT services. It is recognised that many people experience more than one of these conditions.

Table 1: Overview of depression, anxiety disorders and other conditions

Condition	Description
Depression	A mental health problem characterised by pervasive low mood, a loss of interest and enjoyment in ordinary things, and a range of associated emotional, physical and behavioural symptoms. Depressive episodes can vary in severity, from mild to severe.
Generalised anxiety disorder	An anxiety disorder characterised by persistent and excessive worry (apprehensive expectation) about many different things, and difficulty controlling that worry. This is often accompanied by restlessness, difficulties with concentration, irritability, muscular tension and disturbed sleep.
Social anxiety disorder (social phobia)	Characterised by intense fear of social or performance situations that results in considerable distress and in turn impacts on a person's ability to function effectively in aspects of their daily life. Central to the disorder is the fear that the person will do or say something that will lead to being judged negatively by others and being embarrassed or humiliated. Feared situations are avoided or endured with intense distress.
Panic disorder	Repeated and unexpected attacks of intense anxiety accompanied by physical symptoms. There is a marked fear of future attacks and this can result in avoidance of situations that may provoke a panic attack.
Agoraphobia	Characterised by fear or avoidance of specific situations or activities that the person worries may trigger panic-like symptoms, or from which the person believes escape might be difficult or embarrassing, or where help may not be available. Specific feared situations can include leaving the house, being in open or crowded places, or using public transport.
Obsessive-compulsive disorder (OCD)	Characterised by the recurrent presence of either an obsession (a person's own unwanted thought, image or impulse that repeatedly enters the mind and is difficult to get rid of) or compulsions (repetitive behaviours or mental acts that the person feels driven to perform, often in an attempt to expel or 'neutralise' an obsessive thought). Usually a person has both obsessions and compulsions.
Specific phobias	An extreme and persistent fear of a specific object or situation that is out of proportion to the actual danger or threat. This can include a fear of heights, flying, particular animals, seeing blood or receiving an injection.

Condition	Description
Post-traumatic stress disorder (PTSD)	The name given to one set of psychological and physical problems that can develop in response to particular threatening or distressing events, such as physical, sexual or emotional abuse, severe accidents, disasters and military action. Typical features of PTSD include repeated and intrusive distressing memories that can cause a feeling of 'reliving or re-experiencing' the trauma, emotional detachment and social withdrawal, avoidance of reminders and sleep disturbance.
Health anxiety (hypochondriasis)	A central feature is a persistent preoccupation with the possibility that the person has, or will have, a serious physical health problem. Normal or commonplace physical symptoms are often interpreted as abnormal and distressing, or as indicators of serious illness.
Body dysmorphic disorder	Characterised by a preoccupation with an imagined defect in one's appearance or, in the case of a slight physical anomaly, the person's concern is markedly excessive. Time consuming behaviours such as mirror-gazing, comparing features with those of others, excessive camouflaging tactics, and avoidance of social situations and intimacy are common, with a significant impact on the person's levels of distress and/or occupational and social functioning.
Mixed anxiety and depressive disorder	A mild disorder characterised by symptoms of depression and anxiety that are **not intense enough** to meet criteria for any of the conditions described above but are nevertheless troublesome. The diagnosis should not be used when an individual meets the criteria for a depressive disorder and one or more of the anxiety disorders above, such people should be described as being comorbid for depression and the relevant anxiety disorder(s).
Irritable bowel syndrome*	A common functional gastrointestinal disorder. It is a chronic, relapsing and often lifelong disorder, characterised by the presence of abdominal pain or discomfort associated with defaecation, a change in bowel habit together with disordered defaecation (constipation or diarrhoea or both), the sensation of abdominal distension and may include associated non-colonic symptoms. May cause associated dehydration, lack of sleep, anxiety and lethargy, which may lead to time off work, avoidance of stressful or social situations and significant reduction in quality of life.
Chronic fatigue syndrome*	Comprises a range of symptoms that include fatigue, malaise, headaches, sleep disturbances, difficulties with concentration and muscle pain. A person's symptoms may fluctuate in intensity and severity, and there is also great variability in the symptoms different people experience. It is characterised by debilitating fatigue that is unlike everyday fatigue and can be triggered by minimal activity. Diagnosis depends on functional impairment and the exclusion of other known causes for the symptoms.
MUS not otherwise specified*	Distressing physical symptoms that do not have an obvious underlying diagnosis and/or pathological process.

* IAPT services are only expected to treat these conditions if they have developed an IAPT-LTC pathway and have staff who have received training in the treatment of these conditions.

2.2 The impact of these conditions

Depression and anxiety disorders are extremely costly to individuals, the NHS and society.

The impact on the person, families and carers

Depression and anxiety disorders can lead to a range of adverse psychological, social and employment outcomes. These may include:

- **Greater distress and poorer quality of life,** including higher levels of self-reported misery and disruption to a person's social, work and leisure life.
- **Poorer physical health**. For example, people with a diagnosis of depression (compared with those without) have a reduced life expectancy. They are also at increased risk of developing a physical health condition, such as heart disease, stroke, lung disease, asthma or arthritis.
- **Unhealthy lifestyle choices**. Depression is associated with decreased physical activity and poorer adherence to dietary interventions and smoking cessation programmes.
- **Poorer educational attainment and employment outcomes.** There is a higher risk of educational underachievement and unemployment in people with depression and anxiety disorders. For those in employment, there is a higher risk of absenteeism, sub-standard performance and reduced earnings.
- **Increased risk of relapse** if treatment is not appropriate or timely.

The impact on the NHS

Healthcare costs for those with coexisting mental health problems and LTCs are significantly (around 50%) higher.[3] A large proportion of this cost is accounted for by increased use of physical health services (not mental health services).[4] For example:

- depression is associated with increased rehospitalisation rates in people with cardiovascular disease and chronic obstructive pulmonary disease (COPD), compared with the general population[5][6]
- chronic repeat attenders account for 45% of primary care consultations and 8% of all emergency department attendances;[7][8] the most common cause of frequent attendance is an untreated mental health problem or MUS[7][8]
- people with MUS who were not offered psychological therapies as part of their care were found to have a higher number of primary care consultations, than those who were;[9][10] similarly, people with COPD who were not offered psychological therapies as part of their care were found to have a higher number of urgent and emergency department admissions, than those who were.[11]

The impact on society

Together, depression and anxiety disorders are estimated to reduce England's national income (GNP) by over 4% (approximately £80 million).[12] This reduction in economic output results from increased unemployment, absenteeism (a higher number of sick days) and reduced productivity. This is accompanied by increased welfare expenditure.

3 The importance of delivering evidence-based care

The evidence base for the use of psychological therapies for the treatment of depression and anxiety disorders has been regularly and systematically reviewed by NICE since 2004. These reviews led to the publication of a series of clinical guidelines that recommend the use of certain psychological therapies.

3.1 Establishing the effectiveness of psychological therapies

To establish whether a particular treatment is effective, it is important to be able to understand first whether the intervention is beneficial (do people who receive the treatment improve more than people who have no treatment) and, second, what aspect of the intervention leads to the improvement. The optimal method for establishing this comparison is a randomised controlled trial (RCT). Here, a group of people are randomly allocated to different groups and the outcomes of the groups are compared. One group will receive the treatment in question while the other group(s) serve as control or comparison conditions. A group that is waiting for treatment will control for passage of time alone. Other groups might receive a placebo intervention, 'treatment as usual' or another new treatment.

RCTs are essential to finding out the real difference a treatment makes. One of the first RCTs of a psychological therapy for depression compared the delivery of cognitive behavioural therapy (CBT) to treatment with imipramine (an antidepressant) and showed that CBT achieved better results, both at the end of treatment and at follow-up a year later[13].

RCTs are a substantial part of the evidence base from which NICE guidance is established.

3.2 NICE-recommended psychological therapies

NICE-recommended psychological therapies form the basis of IAPT interventions. This is a key principle of IAPT, because adherence to evidence-based interventions optimises outcomes.

IAPT services offer a range of NICE-recommended therapies for depression and anxiety disorders in line with a stepped-care model, when appropriately indicated. Low-intensity interventions (guided self-help, computerised CBT and group-based physical activity programmes) have been identified as being effective for sub-threshold depressive symptoms and mild to moderate depression, as well as some anxiety disorders. For people with persistent sub-threshold depressive symptoms or mild to moderate depression who have not benefited from a low-intensity intervention, NICE recommendations include the following high-intensity psychological interventions: CBT, interpersonal psychotherapy (IPT), behavioural activation, couple therapy for depression, brief psychodynamic therapy and counselling for depression. For moderate to severe depression, high-intensity interventions recommended by NICE include CBT and IPT. Various forms of specialised CBTs are the NICE-recommended high-intensity treatments for specific anxiety disorders. In the case of PTSD and social anxiety disorder, it is recommended that high-intensity treatment is the first intervention because there is not a strong evidence base for low-intensity treatment. See Table 2.

As described in Section 1.3.1, IAPT provides evidence-based psychological therapies for mild, moderate and severe depression and anxiety disorders where a uni-professional approach with or without concurrent medication management, usually by a GP, is appropriate. In the latest IAPT annual report, the initial average severity of IAPT depression

scores was on the borderline between mild-moderate and moderate-severe[c] with not much variability between CCGs. This indicates that people with moderate to severe depression are being treated across all IAPT services despite the common misconception that IAPT services are only appropriate for those with mild to moderate depression. Treatment of people with moderate to severe depression, when appropriate, is important because such individuals are particularly likely to experience a marked reduction in disability and have their lives transformed.

Table 2: NICE-recommended psychological interventions

	Condition	Psychological therapies	Source
Step 2: Low-intensity interventions (delivered by PWPs)	Depression	Individual guided self-help based on CBT, computerised CBT, behavioural activation, structured group physical activity programme	NICE guidelines: CG90, CG91, CG123
	Generalised anxiety disorder	Self-help, or guided self-help, based on CBT, psycho-educational groups, computerised CBT	NICE guidelines: CG113, CG123
	Panic disorder	Self-help, or guided self-help, based on CBT, psycho-educational groups, computerised CBT	NICE guidelines: CG113, CG123
	Obsessive-compulsive disorder	Guided self-help based on CBT	NICE guidelines: CG31, CG123
Step 3: High-intensity interventions	Depression For individuals with mild to moderate severity who have not responded to initial low-intensity interventions	CBT (individual or group) or IPT Behavioural activation Couple therapy[d] Counselling for depression Brief psychodynamic therapy Note: psychological interventions can be provided in combination with antidepressant medication.	NICE guidelines: CG90, CG91, CG123
	Depression Moderate to severe	CBT (individual) or IPT, each with medication	
	Depression Prevention of relapse	CBT or mindfulness-based cognitive therapy[e]	

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[c] Patient Health Questionnaire – 9 items [PHQ-9] score was 17),

[d] If the relationship is considered to be contributing to the maintenance of the depression, and both parties wish to work together in therapy. IAPT recognises two forms of couple therapy and supports training courses in each. One closely follows the behavioural couple therapy model. The other is a broader approach with a systemic focus.

[e] CBT during treatment in the acute episode and/or the addition of mindfulness-based cognitive therapy when the episode is largely resolved. Mindfulness is not recommended as a primary treatment for an acute depressive episode.

	Condition	Psychological therapies	Source
	Generalised anxiety disorder	CBT, applied relaxation	NICE guidelines: CG113, CG123
	Panic disorder	CBT	NICE guidelines: CG113, CG123
	Post-traumatic stress disorder	Trauma-focused CBT, eye movement desensitisation and reprocessing[f]	NICE guidelines: CG26, CG123
	Social anxiety disorder	CBT specific for social anxiety disorder[g]	NICE guideline: CG159
	Obsessive-compulsive disorder	CBT (including exposure and response prevention)	NICE guidelines: CG31, CG123
	Chronic fatigue syndrome	Graded exercise therapy, CBT*	NICE guideline: CG53
	Chronic pain	Combined physical and psychological interventions, including CBT* and exercise	NICE guideline: NG59 Informal consensus of the ETG[h]
	Irritable bowel syndrome	CBT*	NICE guideline: CG61 Informal consensus of the ETG
	MUS not otherwise specified	CBT*	Informal consensus of the ETG

Note:
NICE depression guidance currently being updated.
* Specialised forms of CBT.

See Appendix A in **appendices and helpful resources** for a list of NICE guidance relevant to the conditions treated within IAPT services.

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[f] If no improvement, an alternative form of trauma-focused psychological treatment or augmentation of trauma-focused psychological treatment with a course of pharmacological treatment.
[g] Based on the Clark and Wells model or the Heimberg model.
[h] The NHS England IAPT Education and Training Group (ETG) was convened to undertake a review of problem-specific systematic reviews and extrapolation from NICE guidance for the treatment of depression and anxiety disorders in the context of LTCs and for the treatment of MUS.

4 The workforce

4.1 Ensuring the competence and quality of the IAPT workforce

The right workforce, appropriately trained, with the right capacity and skills mix, is essential to ensuring the delivery of NICE-recommended care. Adherence to the protocols of NICE-recommended therapy is critical to good outcomes. Therefore, the success of the IAPT programme depends on the quality of the workforce.

All IAPT clinicians should have completed an IAPT-accredited training programme, with nationally agreed curricula aligned to NICE guidance (or they should have acquired the relevant competences or skills before joining an IAPT service).[i] High-intensity therapists should be accredited by relevant professional bodies. All clinicians should be supervised weekly by appropriately trained supervisors.

The IAPT workforce consists of low-intensity practitioners and high-intensity therapists who together deliver the full range of NICE-recommended interventions for people with mild, moderate and severe depression and anxiety disorders, operating within a stepped-care model. National guidance suggests that approximately 40% of the workforce in a core IAPT service should be PWPs and 60% high-intensity therapists. For the new IAPT-LTC services it is recommended that there is a slightly stronger focus on high-intensity interventions with the workforce being 30% PWPs, 60% high-intensity therapists and 10% senior therapists (such as clinical and health psychologists) who have expertise in LTCs/MUS and can manage more complex problems as well as providing supervision to others.

All current IAPT curricula and training materials can be found on the IAPT section of the HEE website.

Low-intensity workforce

PWPs deliver Step 2 low-intensity interventions for people with mild to moderate depression and anxiety disorders. All PWPs should have completed an IAPT training course, or be in the process of doing so. The core IAPT low-intensity courses for PWPs are accredited by the British Psychological Society. PWPs who work in the new IAPT-LTC services are also expected to have completed the relevant IAPT continuing professional development (CPD) course for working with LTCs and MUS.

High-intensity workforce

High-intensity therapists deliver a range of Step 3 NICE-recommended evidence-based therapies, outlined in Table 3. Therapists need to have been trained in the particular therapy or therapies that they deliver in IAPT, with linked professional accreditation with the relevant professional body. Commissioners and providers should ensure a choice of therapy is offered when NICE recommends several different therapy modalities for the same condition.

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[i] It is recognised that a proportion of the workforce may have acquired relevant competences or skills before the development of IAPT training programmes; such professionals are expected to be accredited by a relevant professional body that is recognised by IAPT.

Table 3: High-intensity therapies and accreditation

High-intensity therapy type	Explanation of NICE-recommended therapy type	IAPT curricula	Course accredited by
Cognitive behavioural therapy (CBT)	A range of specialised CBT protocols for people with depression and anxiety disorders	[Curriculum for High-Intensity Therapies Workers](#)	[British Association for Behavioural and Cognitive Psychotherapies](#)
Counselling for depression (CfD)	IAPT offers a particular type of counselling that has been developed for people with depression	[Curriculum for Counselling for Depression](#)	[British Association for Counselling and Psychotherapy](#)
Couple therapy for depression	Couple therapy can help people with their relationship and emotional difficulties that sometimes flow from problems between partners	[Curriculum for Couple Therapy for Depression](#) [Curriculum for Behavioural Couples Therapy for Depression](#)	[Tavistock Relationships](#) [British Association for Behavioural and Cognitive Psychotherapies](#)
Brief dynamic interpersonal therapy (DIT)	Brief psychodynamic psychotherapy developed for treating depression. It includes a focus on difficult things in the past that continue to affect the way people feel and behave in the present	[Curriculum for High-Intensity Brief Dynamic Interpersonal Therapy](#)	[British Psychoanalytic Council](#)
Interpersonal psychotherapy for depression (IPT)	Time-limited and structured. Its central idea is that psychological symptoms, such as depressed mood, can be understood as a response to current difficulties in relationships and affect the quality of those relationships	[Curriculum for Practitioner Training in Interpersonal Psychotherapy](#)	[Interpersonal Psychotherapy Network UK](#)
Mindfulness-based cognitive therapy (MBCT)	A brief psychological therapy specifically designed to prevent relapse in individuals with a history of recurrent depression. Treatment is often delivered in groups and starts after an initial intervention for an acute episode has been completed	[Curriculum for Mindfulness-based Cognitive Therapy](#)	
LTCs/MUS	Continuing professional development programme for already-trained and accredited high-intensity therapists covering additional competences for working with LTCs/MUS	[National LTC CPD Curriculum for High-Intensity Therapists](#)	

4.1.1 Clinical leadership

Effective leadership is essential to create a culture of shared and distributed leadership for all staff to take accountability for performance and drive forward continuous quality improvement. Balancing effective and efficient service delivery with compassion, and keeping person-centred coordinated care at the centre by involving patients in the development and improvement of services, are important actions to guard against the potential negative effects of target-driven cultures. Leaders must ensure that delivering evidence-based NICE-recommended therapies remains at the heart of service provision through effective clinical governance.

Transformational leadership can be challenging in the context of difficult financial situations, staff turnover and performance demands from local commissioners and NHS England. However, leadership should facilitate improved patient outcomes and result in staff feeling supported and appreciated, at the same time as creating an innovative environment in which the information captured by IAPT data reports is seen as a source of good ideas that everyone can participate in, rather than a mechanism for harsh performance management.

See Section 9.1.5 for more detail on the importance of developing good clinical leadership.

4.1.2 Additional workforce

Managers should balance a supportive, nurturing and innovative environment in which staff can thrive with a focus on achieving the national standards through performance management.

It is important to connect regularly with clinical networks that have a remit for quality improvement, use data to drive improvements, share good practice and support regional training solutions. Attending organised events can support and enhance local delivery.

Building relationships with key stakeholders, including GPs that can champion the service, and connecting with the wider system will support local pathway development and ensure patients get to the right service at the right time.

Employment advisers (or working closely with advisers) are within the original design of the IAPT programme and as such should be commissioned as part of the IAPT service to realise the full benefit. See Section 11.5 for further detail on this important role within IAPT services.

Data analysts have a crucial role within an IAPT service because data quality is a key feature of the success of the IAPT programme. Ensuring alignment of national and local reporting is an essential task since commissioners are performance managed on national, not local, reports. Providing more in-depth local reports for analysis can support staff and managers to understand and improve the quality of the service provided.

Administrative staff are essential to the effective functioning of services. A robust administrative system can support productivity and, with the implementation of lean systems, can support timely access in to the service, as well as efficient mechanisms to support the flow through the system.

4.1.3 Competences and training

To be effective, NICE-recommended psychological therapies need to be delivered by individuals who have developed all the relevant competences that underline the treatments. Roth and Pilling have developed a competence framework for each of the therapies

supported by the IAPT programme. Courses that are delivering the agreed IAPT training curricula assess trainees against this competence framework. Experienced clinicians may also wish to consult the framework when considering the need for any CPD. Commissioners should be familiar with the framework to ensure that services are employing clinicians with the relevant clinical skills. See Appendix B in **appendices and helpful resources** for more detail.

All clinicians within an IAPT service should also receive training on working with the specific experiences of people with protected characteristics. Further information and resources can be found here. Additional detail can also be found in Section 10.

The importance of in-service training

A key feature for the IAPT programme is the in-service training opportunity. Trainees have the advantage of being able to practice, daily, the required skills for the therapies they are being trained to deliver, with the people who are experiencing the relevant clinical problems. Initial training cases should not be overly complex. Caseloads should be reduced to encourage reflective practice. Modelling is one of the optimal ways of learning clinical skills, so it is strongly recommended that trainees have an opportunity to sit in on therapy sessions with more experienced clinical staff.

Continuing professional development (CPD)

CPD is critical to improving outcomes for people receiving treatment and for supporting staff wellbeing. Regular CPD opportunities should be provided for all IAPT staff aligned to individual needs, professional body requirements and to the therapies that they are delivering, this should also form part of the supervision process (see Section 4.1.4). Access to high-quality reports can facilitate a targeted approach to CPD by highlighting areas of developmental need.

A key quality standard for IAPT services is to maintain a stable core of trained, accredited clinicians who represent a mix of seniority across the different therapeutic modalities and can support others in their development. Developing staff (including PWPs) for more complex roles or maintaining performance levels in existing roles is important to enable a balanced skill mix to support more complex clinical work, as services need to build capability and capacity to safely manage severe and complex cases.

4.1.4   Supervision

Supervision is a key aspect of quality assurance as part of a robust governance process, and is fundamental to the success of the IAPT programme. The three essential functions of supervision are to improve outcomes for people receiving treatment, provide support to individual clinicians, and improve clinician performance and professional development.

A supervision competency framework was developed for the IAPT programme and the IAPT Supervision Guidance provides support and guidance on the different types of supervision within the IAPT service.

IAPT eligibility criteria exist for all supervisors within IAPT services and all supervisors should have completed one of the IAPT supervisor-specific training programmes. A named senior therapist should be responsible for overseeing the effectiveness of supervision within the IAPT service, in conjunction with the clinical director and course directors concerned.

Principles of effective supervision:

- a key characteristic of the IAPT programme is outcomes-focused supervision
- supervision should take place weekly, consisting of at least one hour of individual supervision with an experienced and trained supervisor located within the IAPT service
- small group supervision that is proportionally longer in duration can also be effective
- every 2 to 4 weeks all ongoing clinical cases should be reviewed in supervision
- case discussion should be informed by outcome measures
- PWPs should receive both case management supervision (individual, one hour per week) and clinical skills supervision (at least one hour per fortnight)
- discussion of clinical cases should be prioritised according to need
- cultural competence should be considered, as well as how supervision can support the supervisee to meet individual need
- additional supervision for trainees:
  - high-intensity trainees should receive additional supervision of training cases, lasting 1.5 hours within their two-day attendance on the course at a university
  - PWP trainees should receive an additional 1 hour per fortnight individual and group supervision, focused on case discussion and skill development (in addition to case management supervision).

4.2 Staff wellbeing

Staff wellbeing is paramount. Creating a resilient, thriving workforce is essential to delivering high-quality mental health care as staff wellbeing correlates to better outcomes for patients. A highly challenging professional context should be matched with high levels of support. Productivity aspirations should be based on workloads that are consistent with professional and ethical guidelines for sustainable quality of care.

As good practice, providers should implement local strategies to improve and sustain staff wellbeing. It is recommended that services have a written plan for supporting staff wellbeing, which is shared with staff and updated on a regular basis. Key elements could include:

Good leadership and good management:

- effective clinical leadership (see above), clear line management with excellent team communication, attention to staff support, openness to feedback, and alertness to signs of stress in the workforce
- training and support for line managers to allow them to manage staff effectively and compassionately, particularly in relation to performance management.

The right working environment:

- ensuring a healthy and safe working environment where staff are equipped with the resources and equipment needed for their roles, including an appropriate IT system and admin staff support
- ensuring staff have sufficient time to manage their caseloads and deal with unpredictable risk issues within their contracted working hours
- staff should have time for appropriate lunch and other breaks and should not regularly work overtime.

Effective supervision:

- ensuring weekly outcomes-focused supervision with appropriately trained supervisors
- encouraging variety and autonomy in the job role, such as PWPs having the opportunity to deliver treatment interventions via a range of formats – phone, one-to-one, groups and digitally, and choosing how they manage their own diaries within service requirements can enhance job satisfaction.

Appropriate levels of clinical complexity:

- service operates within the IAPT framework, allowing the staff to work with IAPT-appropriate cases for which they have received suitable training
- access to, and presence of, more experienced staff to support working with more severe or complex cases, and managing risk issues when they arise.

Training and CPD:

- providing ongoing CPD relevant to the role and targeted to the individual needs of clinicians, as identified in supervision
- opportunity to join special interest groups
- profession-specific forums to develop further skills and expertise
- career development opportunities
- introduction of staff wellbeing champions
- supporting trainees to fulfil the training requirements of their course, recognising that they cannot deliver the workload of qualified staff, and manage uncertainty linked to fixed-term contracts and job security.

Wellbeing initiatives:

- ensuring that all staff have had training in dealing with the emotional aspects of their role
- developing 'top tips for looking after yourself and managing wellbeing' for all staff, and ensuring that staff have a chance to follow-up on the tips.

A supportive culture:

- staff engagement and input in decision-making, service improvement and managing change
- a staff wellbeing agreement could be included in the local induction process to help shape a culture that puts service users and staff at the heart
- staff turnover should be monitored via 'exit interviews' and any learning implemented to improve retention
- incorporating wellbeing activities to support team building; this facilitates resilient teams and team effectiveness which is linked to improvements in the quality of care patients receive
- identify whether any staff spend an excessive amount of their time in lone/isolated working and take steps to reconnect them to the IAPT team
- providing timely and appropriate occupational health services, when required
- staff wellbeing should be an ongoing agenda item in team meetings, and discussed in both supervision and appraisals.

4.3 Workforce retention

4.3.1   Key aspects of maintaining a thriving workforce

In IAPT services staff retention of high-intensity therapists is generally good. However, there has been some difficulty in retaining the low-intensity workforce (PWPs) in role. In particular, a large number of PWPs move into high-intensity therapy training after a very short period in role. While it is encouraging that these individuals remain committed to the IAPT programme, it is difficult to maintain national standards if individuals only stay in role for a very short period after training. It is expected that qualified PWPs stay in role for at least 2 years after completing their training, and services should aim to recruit staff from a range of backgrounds to create a diverse workforce with a substantial number of people who will be keen to continue developing within the PWP role.

Standards of good practice for the retention of the PWP workforce

Recognition of the value PWPs bring and effectively integrating them into the team is crucial.

It is important to have a wide range of development opportunities within the PWP role to retain staff who want to develop their skills and progress within the role. Newly qualified PWPs need to consolidate their skills and be supported with any skill or confidence deficit between their training and the reality of their job. Experienced staff need new opportunities to develop.

Developing specialities and variety within the role can support retention. This can be achieved by creating 'champions' within the PWP role and across areas of service improvement and development. For example, champions for older people, black, Asian and minority ethnic (BAME) groups, younger adults,[j] perinatal services, military veterans and people with LTCs or MUS. Creating these opportunities can enhance and widen the practitioner's skill set through gaining experience in project management, stakeholder engagement and partnership work, as well as more specialist clinical skills. Such roles can also lead to PWPs being recognised for their work within the service and have the potential for increased salary banding.

Career development opportunities, such as senior PWP and lead PWP positions, as well as offering attendance at accredited supervision training, can also support retention. These opportunities, alongside a commitment to CPD, can lead to staff feeling valued within the PWP profession.

4.4 Workforce data collection

To support workforce planning and the commissioning of training, accurate data on IAPT workforce is required from all IAPT services. This is usually collected at an institutional level, via the Trust or Independent/Third Sector HR departments using the workforce minimum data set collected by NHS Digital.

All IAPT services are required to record their workforce accurately according to the occupational codes required by the NHS workforce data standard. This will require updating of historic workforce coding to reflect the most current coding scheme. All IAPT Providers (NHS, independent and third sector) are required to supply the Workforce Minimum Data Set to NHS Digital to allow accurate tracking of workforce.

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[j] People aged between 18 and 25 years.

5 Delivering effective assessment and treatment

5.1 A good assessment

A person-centred assessment completed by a trained clinician is a crucial part of the IAPT care pathway. A good assessment should accurately identify the presenting problem(s), make an informed clinical decision about the person's suitability for the service, determine the appropriate NICE-recommended treatment and step in collaboration with the person, and identify the correct outcome measure to assess change in the problem(s).

5.1.1 Components of a good assessment

IAPT services should provide a person-centred assessment that covers the following areas:

- **Providing information about the service.** People should be given clear information about the IAPT service, the clinician's role and the purpose of assessment, including information about confidentiality and informed consent
- **Presenting problem(s):**
  - a clear outline of the person's presenting problem(s) (including symptoms)
  - the person's view of the main problem(s) and the impact on their life
  - any history of mental health problems
  - an exploration of any psychological processes that are likely to maintain the person's presenting problems, such as:
    - safety behaviours and avoidance
    - attention
    - memory
    - problematic beliefs
  - an exploration of any adverse circumstances that maintain a person's presenting symptoms, this could include factors such as:
    - debt
    - domestic violence
    - isolation
    - homelessness or inadequate housing
    - relationship difficulties
    - employment status
    - information about the person's use of prescribed and non-prescribed medication (for example, drug and alcohol misuse)
  - identification of the appropriate problem descriptor(s) (ICD-10 code)
  - the person's goals for treatment
- **A risk assessment** (including self-harm or suicide, or harm to others)
- **Completion of the IAPT minimum data set (MDS),** including any appropriate anxiety disorder specific measures (ADSMs) and/or the LTC/MUS outcome measures as indicated by the problem descriptor.

5.1.2 Carrying out an assessment

Clinicians should ensure that assessments are completed in full.

Table 4 has been adapted from University College London's (UCL) PWP Training Review and summarises seven key elements that form an essential part of an IAPT assessment, with a brief description of the outcomes for both the clinician and patient.

Table 4: Summary of seven key elements of an assessment

Type of assessment	Outcome for clinician	Outcome for patient
Screening/triage	Decision as to service eligibility and/or priority	Knows whether is accepted by service
Risk	Rating of degree of risk	If risk, knows the clinician has recognised this and agreed a plan
Diagnostic: including screening for all IAPT conditions	Accurate problem descriptor	Knows how the problem is defined and therefore understands the rationale for treatment intervention
Mental health clustering	Allocation to mental health cluster	Accesses the right package of care
Psychometric: correct outcome measures including ADSMs and MUS	Scores on measures to guide decision-making	Awareness of symptom severity and engagement with outcome measures
Problem formulation	Problem statement summary agreed with person	Able to talk about problems, feel understood and come up with a succinct summary that helps problems feel more manageable
Treatment planning: personalised goals	Agreed goals and decision as to type of treatment (based on the problem descriptor)	Has treatment goals and knows plan for treatment

5.1.3   Establishing the appropriate problem descriptor

NICE guidance is based on the ICD-10. Different psychological treatment approaches are recommended for different types of problem as delineated in the ICD-10 framework. For this reason, it is essential that assessors identify and record a problem descriptor for the main problem that the clinician and patient have agreed they would like to work on. It is recognised that patients may have multiple problems. The IAPT MDS has several problem descriptor fields that can be used in such instances, it is essential that the clinician identifies the ICD-10 code that characterises the leading problem. If this is not achieved, the person may be offered the incorrect treatment and the most appropriate outcome measures may not be used. This will hamper the clinician's attempt to help the person overcome their problems.

Research has shown that mental health practitioners are relatively good at detecting depression but often miss anxiety disorders. Figure 2 from the Adult Psychiatric Morbidity Survey (APMS) 2014 illustrates the problem.

Figure 2: Professional diagnosis of common mental health disorders

Professional diagnosed CMD, by CMD in past week (as identified by CIS-R)

Ever diagnosed with CMD by professional (self-reported)	CMD in past week, as identified by CIS-R			
	Depression	Phobias	OCD	Panic disorder
	%	%	%	%
Depression	70.0	72.1	83.0	43.8
Phobia	5.9	7.2	6.0	–
OCD	7.1	7.9	13.2	–
Panic attacks	42.7	45.5	41.9	22.3
Bases	284	201	103	43[a]

[a] Note small base for panic disorder.

The above information shows that most people who experienced a common mental health disorder in the previous week have had their depression recognised by a mental health professional at some stage in their life. By contrast, less than a quarter of people with an anxiety disorder have ever had that condition recognised by a professional. Of course, living with a chronic anxiety problem can lead to occasional episodes of depression. Interestingly, the data show that these episodes are detected without the underlying anxiety disorder being recognised. IAPT assessments need to avoid perpetuating this problem. Clinicians who have identified that a patient is depressed should continue their assessment to determine whether there is an underlying anxiety problem that needs to be treated. If such problems are not recognised and dealt with, further episodes of depression are highly likely.

To ensure that all relevant problems are identified, it is recommended that assessments include systematic screening for each of the conditions that IAPT treats. Standardised commercial screening questionnaires[k] that cover the full range of problems and that can be completed by people before they attend an assessment can be considered. During the assessment, it is recommended that the full set of IAPT screening prompts are used (see Appendix C in **appendices and helpful resources**).

Avoiding inappropriate use of the mixed anxiety and depression problem descriptor

It is common for people to have an anxiety disorder and also experience an episode of depression. When both are of clinical severity, each should be correctly identified with a problem descriptor. Establishing which problem descriptor is the main one will depend on discussion with the patient, taking into account their views about what treatment should focus on, along with considerations about relative severity and disability.

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[k] For example, the Psychiatric Diagnostic Screening Questionnaire (PDSQ).

The 'mixed anxiety and depression' problem descriptor (ICD-10 code) should **not** be used unless the person's symptoms of depression or anxiety are both too mild to be considered a full episode of depression or an anxiety disorder. Inappropriate use of the 'mixed anxiety and depression' problem descriptor may mean that patients do not receive the correct NICE-recommended treatment. For example, if someone has PTSD and is also depressed they should be considered for trauma-focused CBT as well as management of their depression, but this may not happen if they have been identified as having 'mixed anxiety and depression'.

5.1.4   Selecting the outcome measure

As part of the assessment process it is important for the clinician to ensure the appropriate outcome measure has been selected. If the problem descriptor is linked to a particular anxiety disorder specific measure (ADSM) or medically unexplained symptom (MUS) measure it is essential that the relevant measure is given at every treatment session, in addition to the Patient Health Questionnaire – 9 items (PHQ-9), Generalised Anxiety Disorder scale – 7 items (GAD-7) and the Work and Social Adjustment Scale (WSAS). See Section 6.2 for details. Patient experience questionnaires (PEQs) should be used at the end of assessment and treatment, the results of which should be used to monitor and improve service delivery.

5.1.5   Clustering

Clustering is one index of a person's care needs. As such it supports a pricing and payment model. It can also benefit decision-making within local pathways to ensure patients receive the right level of care. IAPT services should cluster when patients enter treatment.[14] There is no cluster review period and no re-clustering at any point in the IAPT episode of care (including when the person is stepped up or stepped-down). If a mistake is made this can be corrected in a timely fashion but must still reflect the cluster when entering treatment and not any subsequent changes in presentation. It is the provider's responsibility to ensure that all staff are trained to cluster appropriately. Clusters that are common to IAPT services are care clusters 1, 2, 3 and 4 but some patients whose problems fall within clusters 5, 6, 7 and 8 could also be appropriate.

5.2   Delivering effective treatment

To ensure treatment is effective and recovery is promoted, it is an essential and core principle of the IAPT model that NICE-recommended treatment (see Table 2) is provided at the appropriate dose, in line with the identified problem descriptors, and that a choice of therapy is offered where appropriate. NICE recommends that for the treatment of mild to moderate depression and some (but not all) anxiety disorders, a stepped-care model for delivery of psychological therapies is used. The model has demonstrated effectiveness in delivering positive outcomes, while reducing the burden experienced by the person in treatment and also ensuring that a service can see a substantial number of people.

For these benefits to be achieved it is important that stepped care is used appropriately and that treatment is provided, through consultation between the clinician and their case management supervisor, according to the following key principles (see Table 5).

Table 5: The key principles of effective treatment and stepped care

Treatment choice should be guided by the person's problem descriptor	CBT is not a single therapy but rather a broad class of therapies. For example, the indicated CBT for PTSD is very different from that for social anxiety disorder, both of which are different from that for depression. It is essential that clinicians work together with the person to clearly identify the primary clinical problem that they want help with before selecting a treatment type.
A NICE-recommended intervention	A range of NICE-recommended CBT and non-CBT interventions should be offered (see Table 2). This also includes the concurrent use of medication in moderate to severe (but not mild) depression.
Offer the least intrusive intervention first	The least intrusive NICE-recommended intervention should generally be offered first. But it is important that low-intensity interventions are only offered where there is evidence of their effectiveness. For example, a person with severe depression or other types of anxiety disorders, such as PTSD or social anxiety disorder, should normally receive a high-intensity intervention first.
Treatment should be guided by the person's choice	When NICE recommends a range of different therapies for a particular condition being treated, and where possible, people should be offered a meaningful choice about their therapy. Where treatments are on average similarly effective, giving people their preferred treatment is associated with better outcomes. Choice should include how it is provided, where it is delivered, the type of therapy and the clinician (for example, male or female).
Offer an adequate dose	All people being treated should receive an adequate dose of the treatment that is provided. NICE recommends that a person should be offered up to 14 to 20 sessions depending on the presenting problem, unless they have recovered beforehand. The number of sessions offered should never be restricted arbitrarily. People who do not respond to low-intensity treatments (and as such, still meet caseness) should be given at least one full dose of high-intensity treatment as well within the same episode of care.
A minimal wait	No person should wait longer than necessary for a course of treatment. Services should work to a high-volume specification with minimal waiting times for treatment (and within national standards), as well as facilitating movement between steps (see appropriate stepping).
Appropriate stepping	A system of scheduled reviews (supported by the routine collection of outcome measures and supervision) should be in place to promote effective stepping and avoid excessive doses of therapy. This includes stepping up when there is no improvement, stepping down when a less intensive treatment becomes more appropriate or stepping out when an alternative treatment or no treatment becomes appropriate.

5.2.1   Sessions outside of the consulting room

Commissioners should ensure appropriate funding for the right dose of therapy to be delivered according to NICE guidance. Adhering to evidence-based competences for delivering specific therapies for a range of disorders is essential to improving outcomes. Activities described within the competence frameworks ensure best practice and will include sessions outside the consulting room, where appropriate, for a range of anxiety disorders. This can have an impact on service capacity and should be considered when commissioning IAPT services.

Session duration can also vary depending on adjustments made to enable access and when implementing evidence-based interventions for specific anxiety disorders.

Sessions at home should be offered if there are severe mobility issues preventing attendance at clinic. IAPT providers and commissioners must plan for this within the service specification.

6 The importance of data: monitoring clinical outcomes and activity

A key characteristic of the IAPT programme is the routine collection of clinical outcome measures and monitoring of activity. The introduction of session-by-session outcome measures has had an important impact on mental health services.

Before the introduction of IAPT, most psychological therapy services only aimed to collect measures of symptoms and disability at the beginning and end of treatment. As patients do not always finish therapy when expected and clinicians were not in the habit of regularly giving outcome measures, this meant that post-treatment outcome data were missing for a large number of treated patients. Subsequent research showed that this led to services being likely to overestimate their effectiveness because individuals who did not provide post-treatment scores tended to have done less well.[15]

The IAPT programme has addressed this problem by giving measures of symptoms at every session. In this way, if a patient completes treatment earlier than expected, or a clinician forgets to deliver the measure on a particular occasion, there is always a last available score that can be used to assess outcome. Adoption of the session-by-session outcome monitoring system has enabled IAPT services to obtain outcome data on 98.5% of all patients who have a course of treatment.

In IAPT services, data are collected to:
- **Ensure equitable use of IAPT services.** Demographic information on statutorily protected characteristics and socio-economic status can be used to monitor and actively address any barriers to service provision.
- **Monitor and support the delivery of NICE-recommended care**, this includes helping to ensure that treatments are being delivered in a manner that is most likely to be effective (for example, adequate number of sessions, short waiting times).
- **Provide information to the IAPT worker** that will help identify appropriate targets for intervention in the next therapy session (for example, suicidal thoughts, avoidance behaviours, intrusive memories, and so on).
- **Help people to chart their progress towards recovery**. People have reported that they value seeing their scores from completed clinical outcome measures, and how their scores change over time. Therefore, it is important that each person using IAPT services is given this opportunity. As well as helping the person to understand more about their condition, outcomes can support the development of the therapeutic relationship and help to show improvement.
- **Enhance engagement in collaborative decision-making and treatment reviews**. In combination with person-centred care, outcome measurement tools are essential for informing the continuing appropriateness of the chosen treatment and managing the therapy process (including deciding if a different step or type of intervention is required).
- **Support supervision**. IAPT recommends the use of outcomes-focused supervision. During a session the clinician and their supervisor will carefully review the outcome measures, including individual items to assess progress, identify points when the person becomes 'stuck' and plan future sessions.
- **Enhance the overall quality and cost-effectiveness of services.** Service managers can use an outcomes framework to monitor the performance of their service and to engage in constructive discussions with commissioners and clinicians to improve service quality, value for money and outcomes. Local, regional and national leads will also benefit from having accurate, comprehensive outcome data to inform policy-making.

To facilitate the sharing of outcome scores to realise this broad range of benefits, clinical leads and service managers should ensure all IAPT workers have access to up-to-date reports and charts showing the person's progress through the care pathway.

6.1 Collection of routine outcome measures

All IAPT services collect the IAPT MDS on local IT systems. These data flow monthly to NHS Digital for analysis and national reporting. It is the IAPT worker's responsibility to ensure that the person's progress through the IAPT care pathway is recorded.

It is good practice to ask patients to complete outcome measures before the start of a clinical session; this ensures that valuable clinical time is not wasted by the completion of measures. Questionnaires are often completed while a person is waiting for their appointment or earlier on the day of the appointment. On some occasions, the IAPT worker may want the person to complete measures within sessions, to introduce them to the measures and engage them in the process of objective measurement of symptoms.

At the start of the IAPT programme patients whose therapy sessions were delivered over the telephone were often asked to verbally report their symptoms in the session with the clinician entering answers into the IT system. The increasing availability of online portals for questionnaires means that many patients are now able to enter their data via the internet before a telephone call with their clinician; this practice is strongly recommended.

All IAPT services are expected to have local IT systems that support the collection and reporting of the MDS. The systems should allow patients, clinicians and supervisors to view graphical plots of progress during sessions, as well as enabling detailed local reporting and analysis. Automatic flowing of data to NHS Digital on a monthly basis via the Exeter Portal is also required.

6.2 IAPT outcome measures

The IAPT MDS is intended to be used on a session-by-session basis for all individuals receiving treatment in IAPT services. It includes measures of symptoms, disability and employment. Occasionally, the PEQ is also administered so that patients can indicate the extent to which they are satisfied with the service they have received.

The **symptom measures** that are recommended depend on the particular clinical condition that is being treated (problem descriptor). See Table 6.

The main measure of **disability** is the WSAS, which assesses the extent to which a person's mental health problem interferes with their functioning at work, at home, at leisure, socially and with their family. Although disability often decreases as symptoms improve, that is not always the case. For this reason, clinicians need to carefully monitor WSAS scores as well as symptom scores to ensure that people have minimal disability once treatment is finished.

Table 6: IAPT outcome measures by problem descriptor

Main mental health problem (primary problem descriptor)	Depression symptom measure	Recommended measure for anxiety symptoms or MUS	Further option, only used if 'recommended measure for anxiety symptoms or MUS' is missing	Measure of disability
Depression	PHQ-9	GAD-7		WSAS
GAD	PHQ-9	GAD-7		WSAS
Mixed anxiety/depression	PHQ-9	GAD-7		WSAS
No problem descriptor	PHQ-9	GAD-7		WSAS
Social anxiety	PHQ-9	SPIN	GAD-7	WSAS
PTSD	PHQ-9	PCL-5	GAD-7	WSAS
Agoraphobia	PHQ-9	MI	GAD-7	WSAS
OCD	PHQ-9	OCI	GAD-7	WSAS
Panic disorder	PHQ-9	PDSS	GAD-7	WSAS
Health anxiety (hypochondriasis)	PHQ-9	HAI	GAD-7	WSAS
Body dysmorphic disorder (BDD)	PHQ-9	BIQ *	GAD-7	WSAS
Irritable bowel syndrome (IBS)	PHQ-9	Francis IBS Scale *	GAD-7	WSAS
Chronic fatigue syndrome	PHQ-9	Chalder Fatigue Questionnaire *	GAD-7	WSAS
Chronic pain (in context of anxiety/depression)	PHQ-9	GAD-7		WSAS
MUS not otherwise specified	PHQ-9	PHQ-15 *	GAD-7	WSAS

* These measures will not currently be used for recovery and paired scores calculations. When reliable change values are calculated for all of these, we will change the guidance/metric for these calculations.

Note: Recovery, reliable improvement and reliable deterioration rate calculations should be based on the pair of measures highlighted in bold. When the measure in bold in the third column is missing, the recovery calculation is based on the combination of PHQ-9 and GAD-7, if this is different.

Key and cut-off scores: PHQ-9 – 10 and above; GAD-7 – 8 and above; Obsessive-Compulsive Inventory (OCI) – 40 and above; Social Phobia Inventory (SPIN) – 19 and above; Agoraphobia-Mobility Inventory (MI) – above an item average of 2.3; PTSD Checklist for DSM-5 (PCL-5) – 32 and above; Panic Disorder Severity Scale (PDSS) – 8 and above.

Further information on these measures can be found in **appendices and helpful resources**.

6.2.1 Anxiety disorder specific measures (ADSMs) and specific measures for MUS

Most people who are seen in IAPT services report significant levels of both depressive and anxiety related symptoms. For this reason, patients are asked to complete measures of both at every session. The PHQ-9 is used as the depression measure for all patients. The GAD-7 is the default measure for anxiety. This scale was originally developed to assess the severity of anxiety symptoms in generalised anxiety disorder only. Patients with other anxiety disorders often also show elevated scores on the GAD-7 and it has come to be used as a measure of change in these conditions as well. However, it has a marked disadvantage in that it does not cover key symptoms that should be targeted in therapy for particular anxiety disorders. The omitted symptoms include:

- social anxiety disorder (fear or avoidance of social situations)
- agoraphobia (avoided situations and whether it matters if the person is alone or accompanied)
- OCD (obsessions and compulsions)
- panic disorder (panic attacks and fear of such attacks)
- PTSD (intrusive memories and avoidance of trauma reminders)
- health anxiety (hypochondriasis).

Given these omissions, IAPT guidance now recommends that clinicians also administer a well validated measure that is specific to the symptoms of these particular disorders, if they are the main focus of treatment. This ensures that clinicians are able to focus on relieving the symptoms that most distress people. Inspection of item-by-item responses on ADSMs can be particularly informative. For example, the PCL-5 is used to monitor progress in PTSD. Some items on this scale measure intrusive memories and others measure avoidance of reminders. If a person shows a reduction in the frequency of intrusive memories the clinician will want to check that the reduction is a genuine improvement rather than simply a result of the person avoiding more. In the latter case, the clinician would need to focus the next few sessions on overcoming avoidance.

NHS Digital use the PHQ-9 and the relevant ADSM to calculate recovery and reliable improvement, when matched with the problem descriptor. With IAPT-LTC services this is now extended to the PHQ-15, the Francis IBS Scale and the Chalder Fatigue Questionnaire. If these additional measures are missing, recovery is calculated using the PHQ-9 and the GAD-7.

6.2.2 IAPT-LTC and MUS outcome measures

To support the implementation of The Five Year Forward View for Mental Health, LTC and/or MUS data will be collected. The following briefly describes and lists the LTC/MUS outcome measures:

- **Mental health outcomes:** a primary outcome that will be used to calculate recovery based on paired outcomes for:
  - PHQ-9, *and*
  - GAD-7 or an ADSM, *or*
  - an MUS measure (Francis IBS Scale, Chalder Fatigue Questionnaire or PHQ-15[i])
- **Perception of physical health:** it is important to measure a person's perception of how their LTC impacts on their overall functioning and how this might change over the course of treatment:
  - Diabetes Distress Screening Scale
  - COPD Assessment Test (CAT)

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[i] A 15-item somatic symptom severity scale.

    o Brief Pain Inventory.

6.2.3 Patient experience questionnaires (PEQs)

It is important that patients have an opportunity to comment on the quality of their care. PEQs are specifically designed to provide this opportunity. Services are encouraged to give all patients the Assessment PEQ at the end of their last assessment contact and the Treatment PEQ at the end of their course of treatment, or at the penultimate session if that is more convenient. It is important that these are administered in a way that ensures that patient responses are confidential. The PEQs should never be completed in the presence of the clinician.

In addition to confidential completion of the PEQ, clinicians should facilitate a relationship where patients feel sufficiently confident to voice any concerns about the progress of treatment within their sessions.

6.3 Data quality

It is the responsibility of all IAPT workers to enter timely and accurate information and scores for each person and each appointment session. Commissioners and providers should ensure that robust data quality and information governance processes are in place and that staff receive the appropriate training to ensure ongoing adherence. This includes adherence to technical guidance, the correct way to capture referral dates (the date the referral is received) and what constitutes 'entering treatment' to ensure that national reports accurately represent the access, recovery and waiting time standards of the provider.

6.3.1 Paired-data completeness

> High levels of session-by-session data completeness are essential. IAPT requires a minimum of 90% data completeness for pre/post-treatment scores from all clinical contacts, including face-to-face, telephone and other methods such as email. However, most services now comfortably exceed that minimum level, the national average is now 98% data completeness.

Data completeness is critical for:
- delivery of NICE-recommended treatment
- effective clinical governance
- enhanced patient experience
- local and national service evaluation.

6.3.2 Missing data

Missing outcome data may be caused by several factors, including the person's distress or objection to its collection, language or reading barriers, perceived administrative burden and a lack of understanding of the importance of collecting data. This should be addressed where possible, so that people who leave treatment in an unscheduled manner will have some evidence of their progress before they leave the service.

When outcome data are not collected in every session, this can mean that end of treatment scores are unavailable. Missing end of treatment scores can lead services to overestimate their effectiveness as people whose scores are missing tend to have improved less.[15] Complete data is crucial for improving service quality and effectiveness.

People may also exercise their right to refuse to provide the information requested at any time. However, a mutually acceptable and effective therapeutic relationship can help to encourage data submission.

6.4 National standards

The IAPT MDS includes a large number of measures that together provide clinicians, commissioners and patients with a comprehensive picture of how an IAPT service is performing. Stakeholders should look at the full range of measures to get a clear idea of the strengths of a service and the areas of focus to enhance further improvement. Two public websites display CCG/service-level IAPT data. These are:
- NHS Digital's reports from IAPT
- Public Health England's Common Mental Health Disorders Profiles Tool

IAPT services have three minimum national standards to achieve (which are described in more detail below):
- access standard: the number of people entering treatment
- waiting time standard
- recovery rate standard.

6.4.1 Access standard

The access standard for IAPT services to achieve by 2015 was 15% of the community prevalence of depression and anxiety disorders (900,000 people). The Five Year Forward View for Mental Health and Implementing the Five Year Forward View for Mental Health set out that this should rise so that at least 600,000 more adults with depression and/or anxiety disorders will be able to access IAPT services each year, by 2020/21.This represents around a quarter of prevalence. Although the general expectation is that local services will increase their capacity by around 66%, the aspirations for individual CCGs are more precisely specified in recently published technical guidance.

Definition of 'entering treatment'
IAPT services should offer a person-centred assessment that provides the patient with information about the service, identifies the patient's problem(s) and suitability for the service, and determines the appropriate NICE-recommended treatment. Some problems are best treated elsewhere in the NHS or with other help (such as debt counselling) and patients are signposted to the relevant service. When problems are very mild, a good assessment and advice may be all that is required.

In the IAPT MDS clinicians can select three different terms to describe the type of initial appointment had with a patient. These are:
- assessment
- assessment and treatment
- treatment.

Patients whose problems are likely to benefit from a course of IAPT treatment will have a series of appointments with the service. These can take place in person, by computer, or over the telephone.

NICE-recommended treatment should be appropriate to the patient's problem and patients should have a choice of appropriate treatments where this is possible. For most problems, a 'stepped-care' model is used. This means that most people with mild to moderate anxiety disorders or depression are offered lower-intensity therapies at first, and 'stepped up' to higher-intensity therapies if they do not respond to the initial treatment. People with more severe anxiety disorders or depression may receive higher-intensity therapies from the beginning of treatment.

Entering treatment is a count of everyone who was seen at least once, had an assessment, was given advice, and was either signposted elsewhere or offered a multi-session course of IAPT treatment, i.e. a patient is coded as having 'entered treatment' if at least one session is recorded as either 'assessment and treatment' or 'treatment'. It is important that these codes are only used when a significant portion of a session is devoted to delivering a NICE-recommended psychological intervention.[16] If a session exclusively focuses on assessment, it should be coded as 'assessment'.

Services should develop written criteria for deciding whether an initial session can be coded by their staff as 'assessment' or as 'assessment and treatment'. Generally, very brief sessions that simply identify that IAPT is not appropriate for an individual should be coded as 'assessment'. However, if any of a range of recognised interventions are a significant focus of the session, it would be appropriate to use the 'assessment and treatment' code. Examples of such interventions include (but are not restricted to): psychoeducation, provision of self-help materials, presenting the rationale for a course of treatment that will start in earnest in the next session, and introducing an internet treatment.
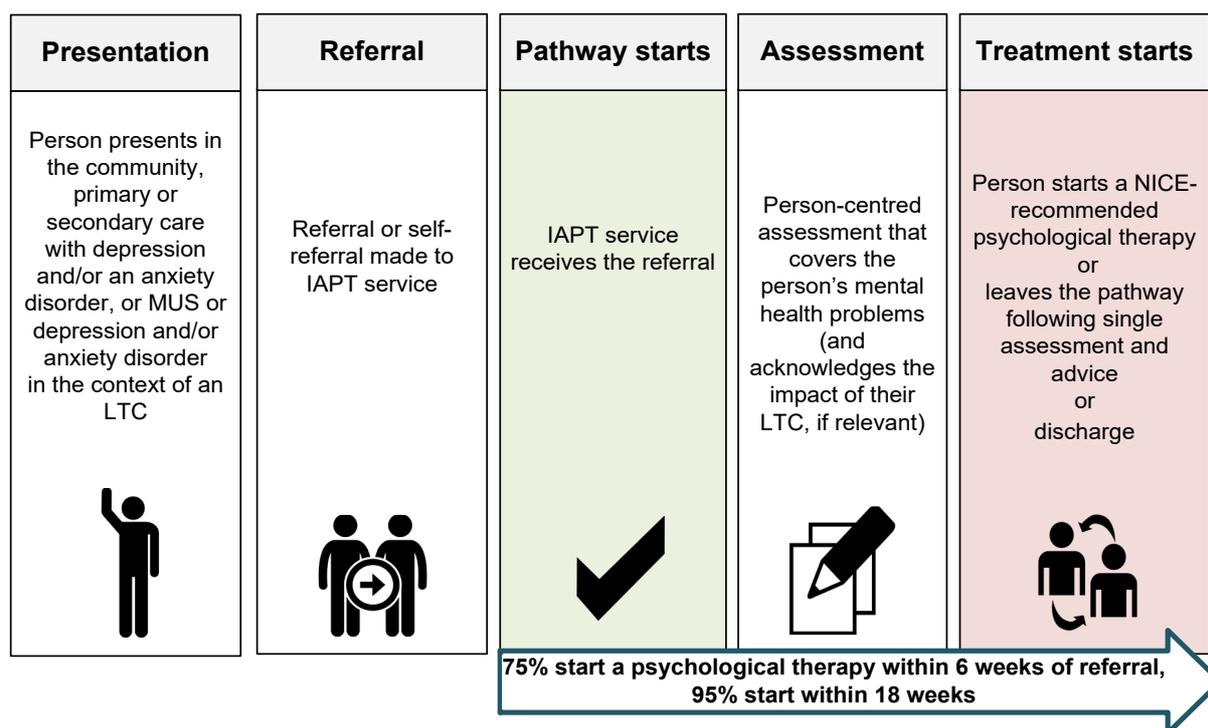
6.4.2   Waiting times standard

The national waiting time standard for the IAPT programme refers to the period of time between the date that an initial referral was received and the start of the course of treatment. Of the referrals that have a course of treatment, 75% should have their first treatment session within 6 weeks, and 95% within 18 weeks. This minimum standard has been established because there is good evidence that patients are more likely to benefit from a course of treatment if it is delivered promptly.

Some patients who are seen in an IAPT service do not go on to have a full course of treatment (two or more sessions), but instead receive an assessment, advice and signposting (if appropriate). To ensure that this activity also occurs in a timely fashion, IAPT also has a secondary waiting time benchmark, which it is recommended commissioners monitor locally. This benchmark applies to everyone who has at least one session in an IAPT service that is coded as 'assessment and treatment' or 'treatment'. Of the referrals that are seen at least once 75% should have their first appointment within 6 weeks, and 95% within 18 weeks.

A summary of the mental health care pathway for IAPT services is set out in Figure 3.

Figure 3: Pathway for IAPT services

Presentation	Referral	Pathway starts	Assessment	Treatment starts
Person presents in the community, primary or secondary care with depression and/or an anxiety disorder, or MUS or depression and/or anxiety disorder in the context of an LTC	Referral or self-referral made to IAPT service	IAPT service receives the referral	Person-centred assessment that covers the person's mental health problems (and acknowledges the impact of their LTC, if relevant)	Person starts a NICE-recommended psychological therapy or leaves the pathway following single assessment and advice or discharge

75% start a psychological therapy within 6 weeks of referral, 95% start within 18 weeks

It is good practice for the waiting time standard to be applied to each of the initial interventions (low-intensity and high-intensity therapies) that are offered during a course of treatment. Services should also guard against in-service pathway waits within a course of treatment. This means that there should not be an excessive wait between the first and second appointment for a particular therapy. If the therapy sessions are generally meant to be weekly or fortnightly then the gap between the first and second session should be similar. For people who are stepped up between low-intensity and high-intensity therapies, the wait between the last low-intensity therapy session and the first high-intensity session should be minimised and certainly should not exceed the waiting time standard for the first intervention. Information on the waiting times for the IAPT programme is published by NHS Digital on a monthly, quarterly and annual basis. In-service pathway waits are also regularly reported.

Further information on monitoring waiting times can be found in the Improving Access to Psychological Therapies (IAPT) Waiting Time Guidance and FAQs.
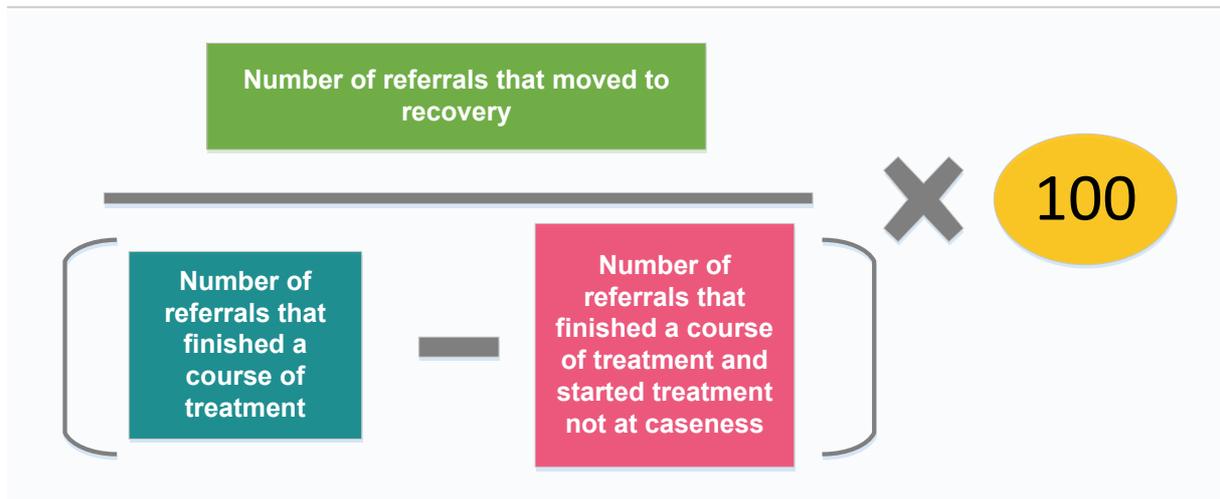
6.4.3 Recovery standard

The national recovery rate standard is that a minimum of 50% of eligible referrals should move to recovery. This national average was achieved for the first time in early 2017. Recovery in IAPT is measured in terms of 'caseness' – a term which means a referred person has symptoms of depression or anxiety that exceed a defined threshold, as measured by MDS outcome measures (including the appropriate ADSM or MUS measure. See Table 6). A person has moved to recovery if their symptoms were considered at clinical caseness at the start of their treatment and below caseness at the end of their treatment.

Recovery rates are calculated based on paired-data outcomes for both the depression (PHQ-9) and the relevant anxiety or MUS measure (see Section 6.2). It is critically important to ensure complete and accurate problem descriptors paired with the correct disorder specific measure, so that these can be counted in the recovery rate calculation (see Figure 4).

A person is considered recovered if their scores on the depression and/or the relevant anxiety/MUS measure are above the clinical cut-off on *either* at the start of treatment, and their scores on *both* are below the clinical cut-off at the end of treatment. IAPT operates a policy of only claiming demonstrated recovery. This means that the small number of patients who have missing post-treatment data are coded as having not recovered.

Figure 4: Recovery rate calculation

Number of referrals that moved to recovery

Number of referrals that finished a course of treatment − Number of referrals that finished a course of treatment and started treatment not at caseness

× 100

Finishing a course of treatment

Finishing a course of treatment is a count of everyone who had at least two treatment sessions in IAPT (including the initial assessment and advice) before discharge. Services aim to record and report the outcomes of all such individuals, irrespective of their reasons for discharge.

Reliable improvement and reliable recovery

A person has shown reliable improvement if their scores on the depression and/or the relevant anxiety/MUS measure have reduced by a reliable amount and neither measure has shown a reliable increase. The reliable improvement calculation applies to everyone who has a course of treatment irrespective of whether they meet caseness criteria at the start of treatment. It is expected that at least two thirds of patients will reliably improve.
A person has 'reliably recovered' if they meet the criteria for both recovery and reliable improvement.

Reliable deterioration

Psychological therapies have the potential to do harm as well as good. For this reason, it is essential that commissioners and providers also monitor whether patients have deteriorated during the course of treatment. A person who is considered to have reliably deteriorated if their scores on the depression and/or the relevant anxiety/MUS measure have increased by a reliable amount and neither measure has shown a reliable decrease. The fluctuating nature of mental health problems means that some reliable deterioration may be expected in the natural course of events but abnormally high deterioration rates should be investigated. See Appendix D in **appendices and helpful resources**.

6.4.4 Taking a broader perspective

The IAPT national standards are not a goal in themselves. It is important for commissioners and providers to remember that the standards are simply aids to help services provide timely and effective treatment. Consideration of the full range of IAPT measures (symptoms, disability, employment and patient experience) is the most appropriate way to determine whether those goals have been achieved.

In some instances, consideration of the full range of IAPT measures may suggest that treatment should continue even when PHQ and GAD/ADSM scores have dropped to a low level. For example, if inspection of the WSAS reveals that a significant degree of interference with everyday functioning is still present, further sessions with an emphasis on functioning may be required. Similarly, if a patient has been out of work because of a mental health problem and would like to rejoin the workforce, further work in collaboration with an employment adviser may be required.

Taking a broader perspective will also help services decide when changes to practice are fully in the interest of providing a broad range of people with depression or anxiety disorders with effective treatment.

Examples of practices that may appear to improve performance on some national metrics but are not desirable when a broader perspective is taken include:
- Refocusing service provision on people with less severe depression and anxiety disorders
- Increasing the use of single session assessment and intervention at the cost of reducing staff capacity to deliver courses of treatment (two or more therapy sessions)
- Immediately discharging people when they get to the recovery threshold (rather than ensuring that they have learned enough to stay well and a maintenance programme is in place).

6.5 National and regional reports

NHS Digital provides national and local (CCG and provider level) aggregate reports based on data extracts submitted each month to the central reporting system. Since April 2015, monthly, quarterly and annual reports have been published. The most detailed report is that which is published once a year (usually in October). Together these reports include summary information relating to:
- **Access**: the number of people entering and completing treatment in relation to geography, gender, age, ethnicity, disability, religion/belief, sexual orientation, employment status and clinical condition
- **Efficiency**: the pattern and duration of interventions, including waiting times and the frequency of multi-step interventions, presented in terms of patient demographic details
- **Data completeness**: the proportion of people who provide complete data on key access criteria, the proportion of people who receive treatment and for whom treatment scores are available at both pre- and post-treatment
- **Effectiveness**: the pattern of outcomes (clinical and social, including employment), the variability of outcomes within and between services, and the relationship of these to presenting problems and medication usage. In addition to the standard metrics of recovery, reliable improvement and reliable deterioration, the annual report also includes pre- and post-treatment means and standard deviations for all outcome measures, plus effect sizes.

Services should not regard central reports as a substitute for local reporting capability. Service data leads are vital in supporting the reporting needs of service managers, supervisors and IAPT workers. Data will require regular validation and local data quality checks will be key to the robustness and reliability of the reporting system. Commissioners are held to account for providers' performance based on national not local reports, therefore services must ensure that local and national data are aligned.

Further information on the IAPT data set can be found on the Public Health England Common Mental Health Disorders Profiling Tool.

7 Getting better results: improving access

By 2020/21 it is expected that 1.5 million adults with depression or anxiety disorders will access IAPT services for psychological interventions each year.

7.1 Expanding the workforce

From small beginnings in 2008, the IAPT programme has steadily grown so that in mid-2017 it was seeing over 950,000 patients per year (237,000 per quarter), with around 60% having a course of treatment, and others having an assessment, advice and signposting (if appropriate). This expansion is largely the result of training and deploying over 7,000 new psychological therapists and practitioners. The Five Year Forward View for Mental Health committed the NHS to further expanding the IAPT programme so that 1.5 million people will be seen in the services by 2021. This will only be possible if commissioners plan for a substantial expansion of the workforce, in line with NHS Planning Guidance for 2018/19 and Health Education England's Stepping Forward to 2020/21: The Mental Health Workforce Plan for England. It is estimated that the average CCG will need to expand the number of clinicians employed in its IAPT service by between 50% and 60%. The exact level of the expansion in particular CCGs will need to be determined by local commissioners but it is clear that no CCG can meet the 2021 access goal without additional clinicians.

7.2 Ways to access IAPT

When depression or an anxiety disorder is suspected, there are a range of access routes available into IAPT services. In addition to referrals being made from primary care and other healthcare professionals, IAPT services also accept self-referrals. This enables people with depression or anxiety disorders to contact services directly, bypassing the need for their GP to always refer them.

7.2.1 Self-referral

The benefits to self-referral were demonstrated in the Newham IAPT pilot site[15] and through analyses of the first year of the programme.[17] They included:

- **Greater equality:** the ethnic mix was more representative of the local population (minority groups were under-represented among GP referrals at the Newham site)
- **Improved clinical reach:** under-represented clinical conditions such as PTSD, social anxiety disorder and OCD were more common among self-referrals
- **Faster treatment response:** self-referrals and GP referrals improved to a similar extent but self-referrals tended to require fewer sessions.

7.3 Best practice

7.3.1 Improving access

There are a number of ways in which commissioners and providers can work to improve the identification rates of depression and anxiety disorders, as well as make IAPT services more accessible to the wider community.

Step 1: Increasing identification rates

Depression and anxiety disorders often go undiagnosed by GPs and other healthcare professionals.

There are a number of ways in which identification rates can be improved:

- Increase mental health awareness and reduce the stigma associated with mental health problems through promotional campaigns and identification of champions within the wider system, including patients and carers.
- Place a strong emphasis on the recognition of mental health problems: NICE recommends that healthcare professionals should be alert to the possible signs of depression or anxiety disorders in 'at risk' individuals and consider using a screening tool where appropriate.[18] This could include the Whooley Questions, Generalised Anxiety Disorder scale – 2 items (GAD-2) or Mini-Social Phobia Inventory Scale (see **appendices and helpful resources**).
- Education and training on mental health delivered to multidisciplinary teams within physical health pathways as part of IAPT-LTC services.

Step 2: Increasing awareness of IAPT services and promoting self-referrals

Professionals and the public need clear and accessible information about how to access local IAPT services and the range of choice available. This is particularly important to promote self-referral, improve access and address the fact that anxiety disorders are commonly under-detected (see Section 5.1.3). This can be achieved in several ways, including:

- promoting IAPT services using clear, accessible and engaging materials distributed in GP practices, job centres, and other community and public places
- services having clear and informative websites that describe the problems they treat and the treatments they offer, including links to NHS Choices – conditions and treatments
- services creating links with local services, such as housing and homeless services, financial support services and Citizens Advice
- services also making local links with third sector and charitable organisations for specific under-represented groups, such as Age UK and Mind
- co-location in primary care and within physical health pathways (IAP-LTC services) in addition to delivering services from multiple community locations
- use of technology, such as:
  - o engaging with the community and voluntary sector social media networks to reach high volumes of people
  - o appealing to different communication and learning preferences by using video clips and animations
  - o developing a patient-focused website that describes the ways in which the service can be accessed (which could include online booking), who the service is for and the available treatments.

Step 3: Improving access via digitally enabled therapy

Digitally enabled therapy is psychological therapy that is provided via the internet with the support of a clinician. There is evidence to show that these therapies can achieve comparable outcomes to face-to-face therapy, when the same therapy content is delivered in an online format that allows much of the learning to be achieved through patient self-study, reinforced and supported by a suitably trained clinician. Many people also prefer to access therapy in this way.

As well as maximising the geographic reach of the IAPT programme, delivering treatment via digital platforms means that treatment can be accessed anywhere and at any time. It can also help promote access to treatment for people who may be less likely to engage with more traditional face-to-face therapy appointments.

8 Getting better results: reducing waiting times

> A key target of the IAPT programme is that 75% of the referrals that have a course of treatment should have their first treatment session within 6 weeks, and 95% within 18 weeks.
> This national waiting time standard refers to the period of time between the date that an initial referral was received and the start of the course of treatment.

The intention of this target is to ensure that no person waits longer than necessary for a course of treatment. However, as set out in Section 6, the IAPT service model acknowledges that some people may benefit from a single treatment session and need no further treatment or are signposted to another more appropriate service. To ensure that this activity also occurs in a timely fashion, IAPT also has a secondary waiting time benchmark which it is recommended commissioners monitor locally. This benchmark applies to everyone who has at least one session in an IAPT service. 75% of the referrals that are seen at least once should have their first appointment within 6 weeks, and 95% within 18 weeks.

To differentiate between the two groups of people and provide greater transparency, the headline indicator will measure waiting times for those people who start a course of treatment, and as such have two or more treatment sessions only. This will be measured retrospectively at the end of the course of treatment.

Pauses will not be taken into consideration when calculating waiting times; instead the national targets have built-in tolerances to off-set this activity (that is, 75% and 95%).

A number of additional measures are captured in national reports to guard against changes to service provision that may have a positive impact on the headline waiting time indicator but are not in the interests of patients. Changes such as these should be avoided:

- giving a larger proportion of patients a single session of assessment and advice, rather than a course of therapy
- reducing the average number of sessions that are given to those people who have a course of therapy
- refocusing service provision on less severe cases
- artificial treatment starts where patients have an early appointment but are then put on an 'internal' waiting list before a full course of treatment starts
- offering a limited choice of NICE-recommended therapies for depression and anxiety disorders.

8.1 Best practice

8.1.1 Making good use of stepped care

It is important for services to implement effective stepped care to maximise capacity. Session-by-session outcome measures, regular reviews and outcomes-focused supervision can support appropriate stepping decisions. Effective stepping ensures that the person receives the right treatment in a timely way and avoids excessive doses of therapy that can impact on service capacity and waiting times.

Joint commissioning of low- and high-intensity therapy services is good practice as it makes it easier to ensure that patients transition smoothly and without undue delays between the

two steps. Where this is not possible, local partnerships should ensure protocols are in place to monitor waiting times across the pathway when people are 'stepped up' to a higher-intensity treatment. Commissioners and providers should aspire to achieve the waiting times standard for all treatments, and put local monitoring in place to ensure that all waiting times are visible and minimised. It is important to ensure the correct data capture of 'entering treatment' (see Section 6.4.1 for definitions) to guard against 'in-service pathway waits', including waiting times from first to second treatment appointment and between therapy types.

8.1.2   Reducing missed appointments

Initiatives that aim to reduce missed appointment rates can play an important role in reducing overall waiting times.

The following service features have been linked to reductions in missed appointments:
- ensuring telephone contact is made with patients to agree initial and rescheduled appointments, rather than sending appointments that have not been agreed (including, making multiple calls on one day if necessary, rather than just relying on voice messages)
- consider implementing an online choose and book system for initial appointments
- advance SMS text reminders of the date and time of an appointment
- robust local processes for managing non-attendance at appointments that are clear and communicated to people entering the service at the point of referral
- person-centred assessments that are carried out routinely in a collaborative manner, ensuring that problem descriptors have been identified and, if appropriate in line with NICE guidance, choice is offered (choice of venue and/or clinician is also offered where appropriate)
- appointments offered flexibly to promote engagement and attendance
- local processes in place to quickly follow-up people who do not attend an appointment and to actively encourage re-engagement, which includes a process that allows for re-assessment if the person feels their needs are not being met
- robust processes for analysing data to look for any patterns in service usage, outcomes, pathways, access and waits. This should also identify missed appointment patterns which may benefit from further investigation and action to reduce reoccurrence.

8.1.3   Offering a choice of delivery

Group work

For some clinical conditions and symptom severities, NICE recommends group work as well as one-to-one therapy (see Table 2). Not all patients are willing to join a group. However, if they find this an acceptable option, group treatment can be a way of reducing the average clinician time per course of treatment which can have a positive impact on waiting times. Groups need to be delivered in line with NICE guidance. Group CBT is a high-intensity therapy option which should be led by a trained high-intensity therapist, perhaps supported by a PWP. Psychoeducation groups, which have a more restricted remit, may be led by appropriately trained PWPs. As with one-to-one therapy, group interventions should involve multiple sessions up to the numbers recommended by NICE for the relevant clinical condition. If patients find they are unable to attend a full course because of timing or other restrictions resulting from group administration, they should be offered alternative one-to-one therapy.

NICE guidance does **not** support the use of single session group wellbeing interventions.

Digitally enabled therapy could be considered as part of the service model design. In this treatment approach, much of the learning that is required to help people deal with emotional difficulties can be achieved by them working through materials on the internet with ongoing contact with a therapist (by telephone, secure messaging, and so on) to provide encouragement, clarify misunderstandings and further enhance learning. Average therapist time per patient can be reduced by using an empirically validated digital therapy programme, and this is likely to have a positive impact on waiting times. However, it is important that patients are always given a choice of digital versus non-digital therapy and that any digital products that are used are ones that are appealing to patients (to minimise drop-out rates) and achieve comparable outcomes to non-digital therapy.

8.1.4   Capacity and demand modelling

Capacity and demand modelling is an invaluable tool for managing waiting times. It supports services to:

Set reasonable standards for clinical contact hours per week.

Clinicians will appreciate clarity on this issue and service cohesion is likely to be enhanced if clinicians can see that clinical loads are fairly shared. Wellbeing and retention should be a key priority in services. Decision-making about clinical hours for both PWPs and HIs should also take into account:

- modes of delivery (phone, face-to-face, online, groups)
- appointment duration (e.g. longer appointments for home visits)
- availability of fit-for-purpose technology (e.g. headphones, laptops, IT)
- liaison with other healthcare professionals (especially for IAPT-LTC)
- meetings and other responsibilities

For high-intensity therapists it is generally considered that achieving 20 face-to-face clinical hours per week is appropriate for a full-time, fully trained individual, with pro-rata reductions for part-time workers, trainees and those with supervision or management responsibilities.

Working towards achieving 18-20 clinical hours per week is generally appropriate for a fulltime, fully trained PWP, with pro-rata reductions for part-time workers, trainees and those with supervision or management responsibilities.

More than 20 clinical contact hours is not recommended and may be detrimental to both wellbeing and clinical effectiveness.

Maximise clinical contact time.

Identifying and removing unnecessary or inefficient administrative processes that reduce the time that clinical staff have for seeing patients. This can include:
- processes to reduce DNAs so overbooking can be kept to a minimum
- travel time
- availability and type of admin support

Develop a service model to improve efficiency and maximise capacity

Services should promote lean referral systems, (over-complicated referral systems create more variation and require more resources).

Simple modelling based on annual contracted numbers is unlikely to have a major impact on waiting times. IAPT providers are encouraged to undertake more detailed modelling that considers requirements for assessment appointments, and for starting Step 2 and Step 3 treatments. Further breakdowns by locations where treatment will be delivered and the individual therapies within each step are also useful.

There are two elements to effective modelling:

1. Ensure that the necessary capacity is in place so that each type of treatment can at least be delivered at the average new demand each week. Capacity calculations need to:
   o be based on realistic expectations of productivity and consider expected loss of capacity due to annual leave, sickness and staff training events
   o consider missed appointments and short-notice cancellations, because rescheduling after a missed appointment requires an extra session of therapist time
   o include the capacity needed to deliver a full course of treatment, not just the first and second appointments.

2. Identify if there are too many patients waiting for each step or therapy modality to meet the agreed waiting standard:
   o A waiting list is defined as all patients waiting for an intervention, irrespective of whether they have been given the appointment date and/or been allocated to a clinician. For example, the first appointment waiting list comprises every patient who has been referred up to the point at which they either attend their first appointment or are discharged prior to attendance.
   o There is a direct relationship between the number of patients waiting for a stage in the pathway and how long those patients will wait. As a rule of thumb, a 4-week wait will be delivered if there are no more than 2-3 weeks of new patients waiting for their first session. A 6-week waiting standard can be achieved with no more than 4-5 weeks of new patients waiting.
   o If there are more patients waiting than the rule of thumb maximum, the excess number is termed the 'backlog'. A one-off resource over and above that which is needed to meet new demand may need to be identified to reduce the backlog.
   o The scale of patients waiting is often shown as 'clearance time' (in weeks). Clearance time is the number of weeks it would take to clear a particular waiting list if no further new patients arrived. Therefore, clearance times give an indication of the size of the waiting list irrespective of the size of the service or actual numbers on the waiting list, and are a useful measure for monitoring variation between, or progress within, a service or waiting list.

Commissioners should ensure that the service capacity required to deliver the identified level of activity is funded recurrently, with performance monitoring and contract levers in place to ensure that the agreed volumes of activity are being delivered.

A good understanding of capacity and demand modelling enables providers to be confident in their estimates of how many staff they require to deliver the expected demand and ensure that there is senior agreement that those staffing levels are in budget and in post.

It is important that there is clarity about who is responsible for clearing backlogs, as well as whether this will be achieved within existing resources, by redesign, by increased efficiencies or if it requires additional (one-off) funding.

8.1.5 Principles of good waiting list management

Sustainable delivery of the access and waiting standards

Commissioners and providers will need to have a good understanding of the sustainability of their IAPT services. That is, the number of referrals, the number of first treatments and the number of subsequent sessions required to achieve the contracted access and wait standards.

Achieving the IAPT waiting standards and a good patient experience

Written pathways with senior clinical sign-off should be in place with agreed waiting standards for assessment, first treatment and all subsequent treatments in line with national IAPT referral to treatment standards.

As far as possible variation in waiting standards for first treatments should be minimised so that all patients can be 'seen in turn'.
- Providers should ensure that there are plans in place to address unequal waits for particular locations, localities and/or clinicians, and for particular therapy types
- Providers should ensure that the number of different queues are minimised, as they lead to inefficiencies.

Commissioners and providers should ensure that there are no avoidable delays after first treatments. This includes, that all waits during a course of treatment are clinically appropriate and part of an agreed pathway. This applies to waits between first and second appointments, but also to waits between later appointments and for the start of new treatments within the stepped-care system.

Patient tracking list (PTL) management

Most IAPT information systems will provide administrative or booking staff with a list of patients on a waiting list for a particular activity. While this can be used for simple booking, it is rarely adequate for proper oversight and management of a team or service.

PTL-style (defined as Patient Tracking List, Patient Target List or Priority Tracking List) waiting list reports are more helpful for visualising where in a system patients are waiting, to identify in which team, modality or area any waiting list pinch-points might be and to give adequate organisational assurance that waiting times standards are being met.

The exact format of the PTLs are for local decision. See Appendix E in **appendices and helpful resources** for examples of PTLs.

A key rule for effective waiting list management is to set up a system in which most patients are automatically allocated appointments based on their order in a list. Management intervention should be by exception. The visual overview provided by a PTL enables managers to focus on areas of concern.

The key features of a PTL are:
- **The setting of a target (or breach) date**
  - For first treatment appointments in IAPT this is straightforward, as there is a mandatory 6-week waiting time standard. Each patient should be offered a date within 6 weeks. Some patients will not be able to take up the offer for good reasons (holidays and so on). This has been considered by setting the service target of at least 75% seen within 6 weeks.

- o For subsequent appointments, internal standards should be agreed that are clinically appropriate. For example, if a therapy is normally based on weekly appointments, gaps between sessions should rarely exceed that amount. Similarly, transitions between one step and another should be timely.

- **Breakdown of waits**
  - o The waiting list can be split by therapy modality and step, by locality, by therapist or other useful divisions. Patients who have been waiting too long can be identified, with target activities agreed.

- **Regular 'PTL meetings'**
  - o It is good practice to review PTLs on a regular (weekly or fortnightly) basis and agree team action

- **Senior oversight and governance**
  - o PTL meetings should be chaired by a senior manager responsible for delivery of performance in the service who has sufficient authority to ensure that agreed actions are followed up
  - o A clear escalation policy should be in place to support booking staff where they are unable to offer appointments within a patient's breach date.

Additional guidance:

The waiting time standards calculations can be found here.

Detailed guidance and FAQs on first treatment definitions and associated terminology can be found here.

9 Getting better results: improving recovery

50% of people treated in IAPT services should move to recovery

From the beginning of the programme, IAPT set itself an ambitious target in terms of clinical outcomes. Consideration of the outcomes that can be achieved with NICE-recommended treatments in clinical trials suggested that it should be possible for around one in two people to achieve recovery and two thirds to show worthwhile improvement. It is reasonable to expect that when the treatments are implemented on a large scale outside of the well-funded environment of a clinical trial outcomes may be less positive. However, the IAPT programme set itself the challenge of achieving something close to equivalence. Initially, the recovery rate was substantially lower than 50% but services have worked hard to refine their clinical procedures and to develop their workforce. Consequently, the national recovery target has now been met (see Figure 5).

Figure 5: National recovery rates
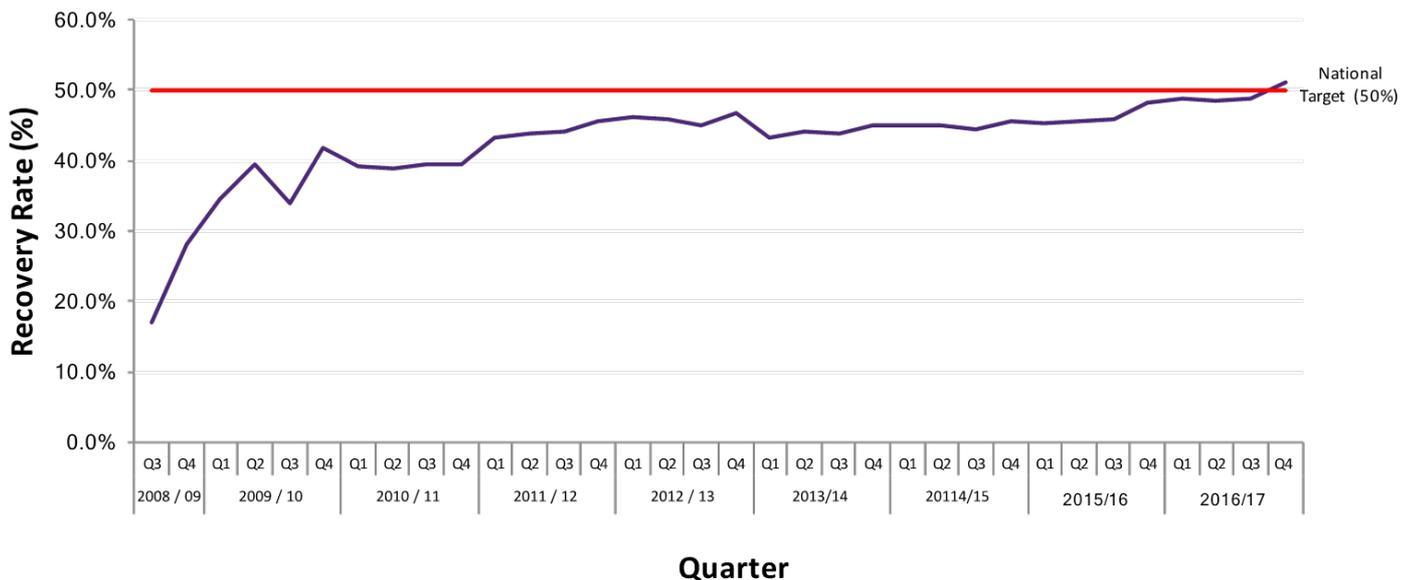
9.1 Best practice

Valuable lessons about how to improve clinical outcomes have been learned during the national journey to 50% recovery.

9.1.1 Importance of NICE-recommended treatment

IAPT services are expected to provide patients with NICE-recommended treatment. However, a minority of patients receive treatments that are not in line with NICE guidance. This creates a natural experiment. Comparisons between the outcomes of patients whose treatment follows NICE guidance and those of patients whose treatment deviates from guidance generally indicate that outcomes are better when NICE recommendations are followed. For example, an early study used patient-level data from the 32 services established in the first year of the IAPT programme to compare the outcomes achieved with

CBT and counselling.[17] NICE recommends both for the treatment of depression (see Table 2). Consistent with this recommendation, there was no difference in the recovery rates associated with CBT and counselling among patients with a depression problem descriptor. In contrast to the recommendation for depression, NICE does not recommend counselling for the treatment of generalised anxiety disorder. Consistent with this position, CBT was associated with a higher recovery rate than counselling among patients with a generalised anxiety disorder problem descriptor.

A further natural experiment emerged in the data for low-intensity interventions. For the treatment of depression, NICE recommends guided self-help but not 'pure' (non-guided) self-help. However, a significant minority of patients received pure self-help. Consistent with NICE, guided self-help was associated with a higher recovery rate than pure self-help among patients with a depression problem descriptor.

9.1.2 Service organisation

Analyses of national IAPT data have identified a number of organisational features that distinguish between services with better and worse clinical outcomes.[17] [19]

Waiting times

Services that have a shorter waiting time between initial assessment and the start of treatment achieve better outcomes. This may be because people lose enthusiasm for engaging in therapy if they have to wait too long after making the decision to come forward for treatment. Waits should ideally not be longer than 6 weeks, in line with the national standard.

Problem descriptor completeness

The NICE-recommended approach to treatment varies according to the clinical condition as specified by ICD-10 based problem descriptors. For some clinical conditions (such as depression) several types of therapy are recommended. For others (such as the anxiety disorders) only one type (CBT) is recommended, but the procedures used can be radically different depending on the particular condition. For example, video feedback is strongly recommended as part of CBT for social anxiety disorder but plays no role in the treatment of PTSD, where there is a much stronger emphasis on memory work. For this reason, assessors in IAPT services are encouraged to work with patients to describe accurately the problems that they would like their treatment to focus on and to give these the appropriate problem descriptor. Identification of the appropriate problem descriptor varies across services, but those with higher rates of problem descriptor identification achieve better outcomes.

Dose of therapy

Services that give a higher average number of treatment sessions achieve better outcomes. The optimal number of sessions appears to be 9 to10 for a service as a whole, but many patients recover with fewer sessions and some need substantially more. In general, patients should be offered **up to** the NICE-recommended number of sessions for the relevant clinical condition. For high-intensity work this would generally be in the range of 12 to 20 sessions, depending on the problem descriptor and severity. It is good practice to offer an initial number of sessions (around 6) followed by a review to decide whether treatment should continue, whether there should be a change of approach (such as stepping up), or whether a reformulation would be appropriate.

Commissioners should ensure that a service has sufficient clinicians to deliver the appropriate dose of treatment.

Missed appointments

Services vary considerably in the percentage of clinical appointments that people miss without notifying the service in advance. Services with higher rates of missed appointments have worse overall outcomes. Service features that are associated with low rates of missed appointments are outlined in Section 8.1.2.

A focus on providing therapy

IAPT services vary in the proportion of referrals that receive a course of therapy, as opposed to just an assessment session, advice and signposting. Services in which a particularly high proportion of people go on to have a course of therapy have better overall outcomes. This is probably because the services and their staff are strongly focused on delivering treatment, rather than a wider range of activities such as general signposting, advice and one session groups.

Making the most of stepped care

Services should offer a stepped-care model that provides people with the appropriate level of care for their needs. Services with higher step-up rates among people who have not recovered with low-intensity interventions have higher overall recovery rates. Stepping decisions should be supported by outcomes-focused supervision and local processes to ensure effective communication with patients.

Social deprivation

In addition to the organisational variables mentioned, analyses of the national data show that the level of social deprivation is a predictor of outcome. Services in more socially deprived areas tend to have poorer outcomes. However, even in the most deprived areas, there are IAPT services that meet the national standards. This is perhaps because research shows that the effect of social deprivation is reduced when organisational variables (see above) are considered. This finding means that if a person lives in a socially deprived area, it is particularly important that they have access to a high-quality IAPT service.

9.1.3 The importance of using the correct outcome measures

Under use of the relevant ADSMs or MUS measures can have a negative impact on patient outcomes:
- patients may not benefit from therapy as much because clinicians are missing critical information to guide therapy (such as, what situations are avoided, whether intrusive memories are a problem, and so on).
- patients may be discharged too early. For example, in a recent clinical trial of psychological treatment for social anxiety disorder most patients achieved recovery on the GAD-7 and PHQ-9 by the midpoint in therapy, but only showed marked reductions in disability and a high recovery rate on the social anxiety ADSM (SPIN) and the PHQ-9 when the full course of treatment was completed. Clinicians who were only guided by the GAD-7 and PHQ-9 would be tempted to discharge patients before they have fully benefited but would be unaware that they are doing so.
- serious clinical problems may be missed. Patients who show marked avoidance (for example, agoraphobia) may not be classified as initial cases on the GAD/PHQ and so would not count towards recovery numbers in a service, even though they may initially be severely disabled (for example, housebound) and subsequently overcome their disability.

ADSMs and MUS measures need to be used routinely to plan treatment and record outcomes, this can be done by:

- ensuring IT systems flag that a particular ADSM or MUS measure is recommended if the relevant problem descriptor is present
- training staff on the value of ADSMs and MUS measures
- using local and national reports to monitor the percentage of cases that had a relevant anxiety disorder as their problem descriptor, and paired scores on the appropriate ADSM following completed treatment
- ensuring internet-based programmes automatically collect an ADSM or MUS measure, if one is relevant
- producing a 'what to expect from your treatment' document that is given to all patients when they start treatment in an IAPT service, including clear information that they can expect an assessment that collaboratively identifies the main problem(s), explains the NICE-recommended treatments for each problem and what they involve, and gives a list of the measures they should be given based on their clinical condition.

9.1.4   A choice of NICE-recommended treatments

When NICE recommends a range of therapies for a particular clinical condition, services should be commissioned so that patients can be offered a choice between the recommended treatments. Research shows that treatments that are considered to be more credible by patients are more likely to be effective. This suggests that the availability of choice is likely to improve clinical outcomes.

Patients should also be offered meaningful choices about where, when and by whom therapy should be delivered. Providing such choice is likely to enhance engagement and, consequently, improve outcomes.

9.1.5   Importance of clinical leadership

In 2015 NHS England invited 12 of the highest performing IAPT services to an event that aimed to identify aspects of the services that might have helped them achieve their excellent outcomes. Data from this event suggested that the quality of clinical leadership in a service is critically important. In all better performing services the clinical leaders had a strong focus on patients achieving recovery, reliable improvement and reduced disability. They helped create an innovation environment in which the staff were interested in the service's outcome data primarily because it indicated how to further improve their clinical work.

Areas of weakness were identified, as were areas of best practice that everyone could celebrate and learn from. The leaders supported staff by enabling them to attend multiple CPD events. Staff also received personal feedback on the outcomes that they achieved with their patients, benchmarked against the service's average. For such benchmarking to be effective, it is essential that it occurs in a supportive environment.

In general, the IAPT programme has benefited from having clear targets for recovery. However, targets are a double-edged sword. Under poor leadership they can appear burdensome and oppressive. Under good leadership they can create an innovation climate.

NHS Leadership Academy provides a variety of resources to support the training and development of staff for leadership roles.

9.1.6 Data-driven reflective practice

Some IAPT services have used the Plan, Do, Study, Act methodology[20] to improve the outcomes they achieve. For a short period of time (say 1 month) the service reviews the notes and other available information on all patients who had not achieved full recovery by the end of treatment. Careful study of the information is then used to think about changes to service provision that might have helped the patients to gain further benefit. These changes are then implemented (Act) and their effect observed. Pimm (2016) reported that this method enabled the large service that he leads move from an average recovery percentage in the mid-40s to a better one in the mid-60s.[21] Several other services have recently implemented the same method with beneficial results.

Developing detailed performance reports that allow outcomes to be monitored by team, modality and problem descriptor is an essential part of reflective practice. Outcomes-focused supervision and live supervision (including session recordings and the use of profession-specific rating tools) can support continual learning. Creating a resilient and experienced workforce that together can help manage a full range of patient problems, including more severe and complex presentations, needs careful consideration. Ongoing planned CPD is essential to ensure staff are appropriately trained and re-trained to treat the problems that they encounter in IAPT services.

It is important to note that people who do not achieve recovery can still achieve worthwhile benefit. It is expected that two thirds of people treated in IAPT services should reliably improve and lead more fulfilled lives by implementing the tools learned in therapy. With this in mind, it is important to analyse local data to understand patterns of improvement and deterioration. In this way services can ensure they are delivering therapy that is safe and benefits the maximum number of people.

9.1.7 Improving engagement in therapy

Increasing motivation

IAPT clinicians should be able to:
* inspire hope, motivation for change and belief in the intervention
* clearly communicate the evidence base, indicating the number of sessions the evidence tells us is required to move to recovery (using an analogy to the use of antibiotics to illustrate the importance of the right 'dose' of therapy to feel better).

Reviews

It is important that treatment is regularly reviewed to:
* check in on the level of engagement
* confirm that the problem descriptor is accurate
* reflect on sessions and progress to date
* plan future sessions in line with the initial goals for treatment.

9.1.8 Commissioning

It is important to ensure that IAPT services are adequately staffed to provide the right NICE-recommended treatment, at the right dose. This includes making provision for: some therapy sessions to be conducted outside the consulting room; longer sessions in line with treatment protocols (PTSD and social anxiety disorder); and for home visits where appropriate (people with agoraphobia or disabilities). Investment must be linked to clear pathways with clarity about what is being commissioned. Providers need to demonstrate they are effective and productive, and make the best use of available funding.

9.1.9 Follow-up after treatment

Common mental health problems can be recurrent and chronic. Psychological therapies have the potential to reduce recurrence by teaching people skills that they can use in the future to reduce the impact of stressful or emotionally challenging circumstances.

Research studies have shown that high-intensity therapies that include relapse prevention procedures in their basic protocol can lead to more sustained gains and reduce relapse when compared with medications.[22] Follow-up of patients treated in the Newham and Doncaster pilot projects also showed that the gains achieved in therapy were largely maintained at follow-up.[15] However, a recent follow-up of PWP treatment in one IAPT service was less positive.[23] Services should therefore not assume that patients will stay well after treatment and instead should put in place a comprehensive set of procedures that are likely to reduce relapse and improve long-term outcomes.

These procedures might include:
- **Focusing on ensuring that patients learn skills for overcoming emotional problems, in addition to meeting symptom recovery criteria**. Some patients, particularly those with mild to moderate depression, could recover during treatment without learning any skills because they were going to recover in that period of time anyway (natural recovery). Such patients will be at increased risk of relapse unless their therapist or PWP ensures that key skills have been learned.
- **Developing a relapse prevention plan with patients before they are discharged**. Typically relapse prevention protocols involve writing out the key learning points from therapy and looking to the future to anticipate any likely stressors or setbacks. A simple plan of how to deal with the stressors or setbacks is then developed and written down. It will involve returning to some of the strategies that worked in therapy (thought records, activity schedules, exposure therapy, social connectedness, and so on) as well as linking up with helpful resources, including contacting their clinician for a booster session, if appropriate.
- **Scheduling one or more post-treatment follow-up sessions**. Follow-up sessions 3 to 6 months after the end of treatment are an excellent way of detecting early signs of relapse that can be dealt with by a brief therapy booster before they become more problematic.
- **Co-ordinating with GPs if a patient is considering stopping medication during follow-up.** Some patients experience a re-emergence of symptoms following discontinuation of medication. This is more likely if medication is withdrawn quickly. Liaison with GPs to agree withdrawal schedules and to monitor patients during withdrawal is therefore advised.

In the future, it is possible that mobile phone apps could be developed to facilitate follow-up. The app could prompt patients to fill in their key outcome measures at regular intervals during the follow-up year, give the patient easy access to their relapse prevention plan, alert the service if relapse has occurred, and facilitate scheduling of booster sessions.

Table 7: Summary of contrast between shared characteristics of better performing and worse performing IAPT services

Better performing services	Worse performing services
Leadership that is focused on recovery and reliable improvement data in an inquisitive and staff supportive manner	Patients are offered a fixed, low number of treatment sessions
Staff get personal feedback benchmarked against the service average or other clinicians	Patients are discharged before recovery despite showing consistent improvement during treatment
Staff wellbeing programmes are in place	Staff wellbeing is not an explicit focus
Most patients receive a course of treatment (mean 62%)	Clinicians are unaware of, or not attending to, clinical cut-offs
Problem descriptors are identified for all people who receive a course of treatment	Patients have been stepped up without a trial at step 2
Regular administration of ADSMs or MUS measures is used to track progress during treatment, when appropriate	Failure to use ADSMs or MUS measures as necessary
Appropriate outcomes-focused supervision, CPD and support of staff wellbeing	Problem descriptors are not used
Effective commissioning of adequately staffed services with clear pathways and avoidance of perverse incentives	'Mixed anxiety and depression' is incorrectly used as the problem descriptor when a person meets criteria for **both** depression and one or more anxiety disorders. Consequently, the service is unable to determine if the correct NICE-recommended treatment has been chosen
Capacity and demand modelling following good principles of waiting list management, including PTLs	Non-guided self-help is given despite not being a NICE-recommended intervention
Short waiting times to the start of treatment without appreciable in-service pathway waits later in the course of treatment	A low percentage of patients receive a course of treatment with high numbers of 'one-off' appointments
Patients are offered up to the NICE-recommended number of treatment sessions, unless they recover earlier	Higher waiting times

9.1.10 Other interventions

Pharmacological interventions. There is a good evidence base on the effectiveness of pharmacological interventions, alone or in combination with psychological therapies for the treatment of common mental health problems. When pharmacological interventions are prescribed, it is important that a close 'partnership' is established with the GP and the IAPT clinician. NICE guidance recommends considering the concurrent use of medication in moderate to severe (but not mild) depression.

Employment support. Close coordination of employment assistance and psychological therapy, with the two running in parallel, is important due to the relationship between work and mental wellbeing (see Section 11.5).

10 Getting better results: improving equity of access and outcomes for all

10.1 Equality-focused services: understanding the local population

At the heart of the NHS constitution is equality and fairness – everyone has an equal right to access and benefit from NHS services. No one group is exempt from depression or anxiety disorders. Therefore, demand for evidence-based therapies remains high across all communities.

Commissioners and providers need to understand the prevalence of depression and anxiety disorders within their local population to extend the reach of their services more effectively. Some groups have a higher prevalence of depression, or anxiety disorders. Other groups may have proportionately lower levels of identification rates, despite high need.

Commissioners should be explicit in their plans about how they will meet the duties placed on them under the Mental Health Act 1983 (amended 2007). To enable commissioners to meet these duties, equity of access and outcomes should be monitored and compared with prevalence of different groups within the local population. Services should be inclusive and actively promote equality, with consideration given to protected characteristics as defined by the Equality Act 2010, and their duties to reduce health inequalities as set out in the Health and Social Care Act 2012.

Service design and communications should be appropriate and accessible to meet the needs of diverse communities (see Guidance for Commissioners on Equality and Health Inequalities Legal Duties). Services should also publish information in a way that enables the public to judge how they aim to eliminate discrimination, advance equality of opportunity and foster good relations between different groups. Commissioners should incentivise improvement in equity of access and outcomes to both support and hold providers to account for meeting the needs of the local population groups.

National data indicate that the following groups tend to be under-represented in IAPT services. Commissioners and service leads are encouraged to inspect their local data to identify under-represented groups in their services, including:
- men
- black, Asian and minority ethnic groups, including people who do not have English as their first language
- people in prison or in contact with the criminal justice system
- servicing and ex-serving armed forces personnel
- refugees and asylum seekers
- lesbian, gay, bisexual and transgender people
- people from deprived communities, including people who are on low incomes, unemployed or homeless
- people with caring commitments
- older people
- disabled people, including the deaf community
- people with learning disabilities[24]

Some IAPT services are commissioned to provide treatment for under 18s. Anyone working with a child or young person should:
- be trained to work with under 18 year olds
- understand their developmental needs and the differences in presentation between children, young people and adults
- be aware of relevant legislation and safeguarding
- use outcome measures validated for this age group.

10.2 Best practice

10.2.1 Developing local care pathways

Commissioners, managers, primary and secondary care clinicians should develop local care pathways in consultation with patient groups and community leaders. Collaboration is critical to enabling access to services for a range of under-represented groups.[18] Working in partnership with patients is paramount to understand and overcome barriers that might hinder the effective shaping of local pathways. Closer working with the voluntary, community and faith sectors will improve access for diverse community groups who may find it more difficult to access services via primary care, such as people from BAME communities.

10.2.2 Workforce, education and training

Commissioners and providers should consider:
- commissioning services that have bilingual clinicians who speak the language of local minority groups, including clinicians who are fluent in British Sign Language (BSL) for deaf people, or commissioning independent translation services
- ongoing CPD to build capability and competence in the workforce, including cultural competence
- ensuring an appropriate skill mix and workforce that is representative of the local population to ensure people have a choice of clinician, for example gender or cultural background.

10.2.3 Improving access and modifying treatments for specific populations

Access for specific populations can be improved by considering the following:
- Choice of venue, as well as gender and cultural background of the clinician, can enable access to services. This can include children's centres, job centres, community centres as well as home visits for people with mobility issues. In line with meeting the needs of the local population, commissioners should ensure that providers have the right level of funding to undertake home visits for both assessment and treatment where appropriate.
- Self-referrals, as people from some sectors of the community are less likely to visit their GP and be identified as having depression or anxiety disorders.[25]
- Promotion is critical to enhancing self-referral. Adapting promotional materials to improve acceptability and engaging with the wider system to promote the service to improve accessibility.
- Prompt and clear routes into the service with no over-complicated referral processes or opt-in systems will support engagement.

Treatments can be modified in the following ways to enhance equity of access and outcomes:
- Adapting session length where appropriate to accommodate pacing and/or use of interpreters.
- Adapting materials to be appropriate to different groups. This includes written communication and visually-based resources available for people who do not speak English as their first language and for people with learning disabilities.
- Use of technology can increase access for people such as young men, older people or people with caring responsibilities or work commitments that may be a barrier to attending therapy. Commissioners and providers should ensure that people are given a choice in how evidence-based therapy is delivered.

10.3 IAPT positive practice guidance

IAPT positive practice guides have been developed to support commissioners and providers to improve equity of access and outcomes for specific groups including:

10.3.1 Long-term conditions

The Long-term Conditions Positive Practice Guide sets out important guidance for working with people with comorbid LTCs, a key requirement in the expansion of IAPT services. LTCs can have a life-changing impact on an individual's wellbeing, functional capability and quality of life. Comorbid LTCs and depression and/or anxiety disorders result in increased use of other healthcare services and increased physical healthcare costs. For these reasons, it is essential to ensure that both mental health and physical health care needs are met effectively.

10.3.2 Perinatal mental health problems
s
The Antenatal and Postnatal Mental Health NICE guideline recognises the serious impact of undiagnosed depression and anxiety disorders on the health and wellbeing of the mother and baby during pregnancy and the postnatal period. Therefore, it is recommended that women in the perinatal period are prioritised for assessment within 2 weeks of referral and commence treatment within 4 weeks.

See the Perinatal Positive Practice Guide for further information on how to understand the needs of parents with perinatal health problems, remove barriers to access, engage parents with perinatal health problems and train and develop the workforce.

10.3.3 Learning disabilities

People with learning disabilities can benefit from IAPT services. With reasonable adjustments and promotion, equitable access to NICE-recommended therapies can be achieved. See the Learning Disabilities Positive Practice Guide for more guidance.

10.3.4 Veterans

The Armed Forces Covenant clearly sets out the nation's commitment to armed forces personnel, their families and veterans. There are additional risks to the mental health of people from this group, such as traumatic combat experiences, time away from family during prolonged or frequent deployment, the instability in home life this can bring and difficulty in the transition back to civilian life.

Commissioners and providers need to understand the demographic profile of their local population and promote access through self-referral or charities as veterans may not be registered with GPs. See the Veterans Positive Practice Guide for increasing access and building capability within the workforce to understand the military culture.

10.3.5 People in contact with the criminal justice system

The Offenders Positive Practice Guide provides commissioners and providers with information on how to understand the needs of people in contact with the criminal justice system, remove barriers to access and continuity of care, and train and develop the workforce.

10.3.6 Older people

Improving access for older people has been incentivised through quality premiums in 2017 to 2019. There are a number of specific actions that can be taken to improve access:
- supporting healthcare professionals to increase identification rates through training and empowering older people to access services
- engaging with the national dementia strategy and national carers strategy
- involving service users, local Age UK groups and other community groups
- taking a flexible approach to offering appointment times, session length and venue, including home visits, depending on level of need
- ensuring training in working with older people is part of ongoing CPD
- promoting the service at various older people's groups and public places, as well as working with other partners to improve access.

IAPT Older People's Training and Resources provides more detailed information and links to resources, including the Older People Positive Practice Guide, the revised IAPT national curriculum for working with older people (2016), and clinicians' guides to providing both low- and high-intensity interventions for older people.

10.3.7 BAME communities

Improving outcomes for BAME communities is incentivised through quality premiums in 2017 to 2019. Key factors to improve equity of access and outcomes for BAME communities include:
- a high level of completeness and accuracy for ethnicity data
- patient engagement and outreach to community groups
- a diverse workforce more representative of the local population
- ensuring cultural competence through ongoing CPD and appropriate outcomes-focused supervision
- adapted materials
- access to high-quality interpreters.

The Black Minority Ethnic (BME) Positive Practice Guide provides more detailed information.

10.4 Key aspirations

Equity of access and outcomes for all will be achieved when:
- the proportion of patients using IAPT services is in line with both prevalence and the local community profile
- a diverse group of people choose to access psychological therapies to improve their mental health
- recovery rates are unaffected by age, race, religion or belief, sex, sexual orientation, disability, marital status, pregnancy and maternity, or gender reassignment.

11 Working with the wider system: improving care

11.1 The need to work with others

Integrating care, particularly physical and mental health care, is one of the key challenges facing the NHS[1]. However, it is consistently reported that integrated care is preferred by individuals who need multiple services. It is also more cost effective, utilising resources more effectively and getting people to the right treatment, at the right time with the right support. [The Five Year Forward View for Mental Health](#) introduced whole-person care that responds to both physical health and mental health. The [Next Steps on the NHS Five Year Forward View](#) set the ambition to 'make the biggest national move to integrated care of any major western country' turning parity of esteem between physical and mental health from rhetoric to reality.[26]

Mental health care is often fragmented from the wider system in addition to the artificial boundaries created between organisations and services making it difficult to offer person-centred coordinated care for physical health, mental health and social care needs. People often suffer as a result of this.[27] Therefore, it is good practice for IAPT services to be commissioned as part of a wider system.[24] Working collaboratively with the wider system will facilitate a positive experience of the journey through the pathways and improve health outcomes.

11.1.1 Co-production

Commissioners and providers should plan and develop IAPT services through collaboration with the people who use the services, their families and carers at all stages. This will help to ensure that the needs of the person and the wider community are adequately reflected in service design and provision.

11.1.2 IAPT sits within a wider landscape of service provision

> 'It is so important that leaders across health reach out to their colleagues… to break down organisational barriers so that collectively, they can ensure people's needs are always put first.'
>
> Source: [Five Year Forward View](#)

Working with the wider system is essential to deliver on the ambition of integration and calls for systems leadership. Commitment from commissioners and provider organisations is critical to influence change and organisational behaviour, creating transformation within the wider system, improving outcomes for patients.

It is important for IAPT services to be embedded within local care pathways to ensure clarity about who is seen, when and where to make referrals to other services that may meet the individual's needs more appropriately. Local discharge and onward referral policies need to be developed to support people as they move to recovery.

Social prescribing is an important part of working with the wider system, facilitating an important link for patients with non-medical sources of support within the community. A number of social prescribing interventions are included within the range of NICE-recommended psychological interventions, such as:

- facilitated self-help
- personal skills development
- bibliotherapy
- digitally enabled therapy.

Social prescribing can support IAPT service delivery through:

- increasing access to a broader range of psychosocial interventions
- increasing the range of providers, including voluntary and community involvement, and
- increasing capacity to respond at an earlier stage.

11.2 IAPT for people with LTCs or MUS

'We should have fewer cases where people are unable to get physical care due to mental health problems affecting engagement and attendance (and vice versa). And we need [the] provision of mental health support in physical health care settings – especially in primary care.'

Source: The Five Year Forward View for Mental Health

In 2016, NHS England published Implementing the Five Year Forward View for Mental Health, which committed to parity of esteem for mental and physical health. By 2020/21, 1.5 million people will access IAPT. Of the additional 600,000 people seen, two thirds of people will have coexisting physical health conditions and will be seen within IAPT services.

Integrating mental and physical health care can ensure a **more proactive approach to mental health** by reducing stigma and promoting mental health awareness. It will allow **faster treatment,** due to the co-location of services reducing barriers and more **effective treatment** due to better understanding of coexisting physical health problems and better tailored care plans.

Workforce integration will be critical to the success of IAPT for LTCs/MUS through skills sharing and treating the 'whole person' to optimise outcomes. This will help to overcome barriers that hinder recognition and treatment of mental health problems with a comorbid LTC or MUS, such as diagnostic overshadowing, presenting with physical symptoms only and the time pressures that physical health teams are under.

Underpinned by core IAPT principles and standards, IAPT services will be required to develop and deliver a new model through integration with physical health care services.

Figure 6: Integrated delivery of care
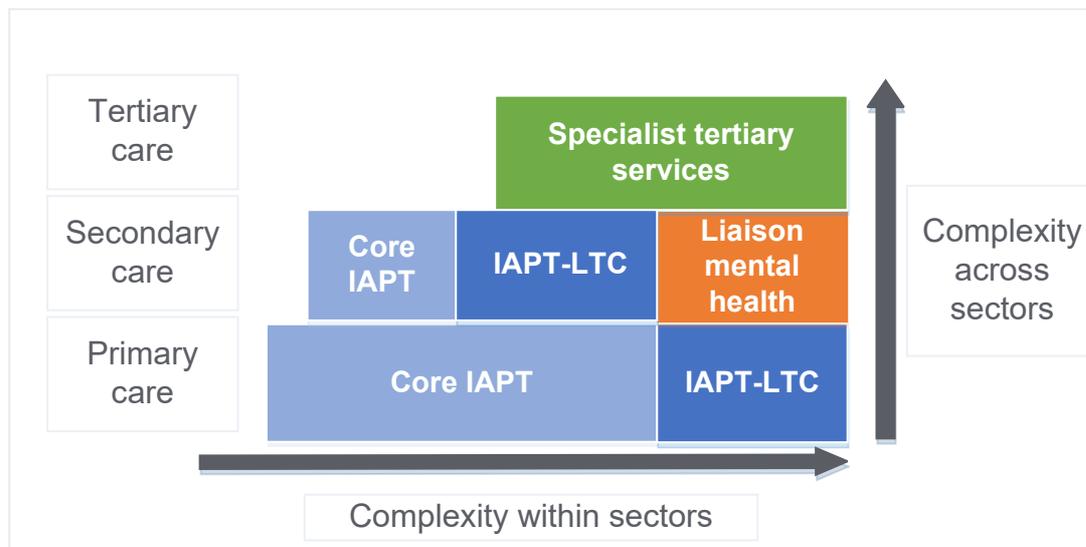
11.3 Primary care interface

The proposals in the General Practice Forward View outline an ambition for 3000 additional mental health clinicians co-located in primary care. It is clear that due to the increasing pressures on primary care services, transforming primary care is a key priority to ensure sustainability.[28] Federations are a developing model whereby GPs join with other professionals in groups of GP practices. This provides commissioners and providers with an opportunity to strengthen the relationship between IAPT and primary care within the evolving landscape.

All services should have a local GP lead who will champion the service. Close collaboration should take place with GPs over the management of medication, so that it facilitates rather than hinders psychological therapy. Co-location in GP practices can improve integration with primary care, supporting a more joined-up approach for people using IAPT services. Where this is not possible, links with primary care should be developed for all people using IAPT services. This is important in order to manage risk effectively through enhanced communication mechanisms and collaboration.

11.4 Mental health service integration

Systems leadership, developing a shared vision and clear strategic direction can support mental health service integration. One example of achieving better integration is shared clinical leadership spanning primary and secondary care services. If this is not in place, effective and reciprocal links can still be established with specialist mental health services to ensure that timely transition across services is achieved when necessary. This includes psychological support for people with more complex needs and enduring conditions, and counselling services for people needing emotional support but not primarily experiencing depression or anxiety disorders. Building relationships with the voluntary and community sector that offer a range of mental health services is an important part of developing local care pathways.

11.5 Employment support

There are poorer employment outcomes for people with coexisting mental and physical health problems. There is a high risk of unemployment, absenteeism and poorer performance[29]. It has been established that the longer people are absent, or out of work, the more likely they are to experience depression and anxiety. Therefore, employment advice, delivered as a core part of an IAPT service, can be integral to the success of that service.

IAPT staff should work alongside employment and welfare advisers, whenever that is what people need. For this reason IAPT guidelines have always said that each team should include one employment specialist for every eight therapists[4] Employment advice, debt counselling and other social assistance should be available within the IAPT service and offered as part of an integrated care plan with close liaison between clinicians and advisers from the point of assessment, through treatment and to discharge.

Employment advisers in IAPT work directly with individuals who are in employment, as well as people who are out of work on health-related benefits. They provide practical advice and relevant intervention to help individuals retain employment or enter the workplace. There is scope to adapt aspects of service delivery at a local level.

Employment support coordination aims to ensure IAPT services are sufficiently integrated with relevant employment bodies at a local level. This can include building relationships with Jobcentre Plus, Work Programme and other relevant employment support providers, local chambers of commerce and local employers. Employment support coordination generally operates at a strategic level and does not have a caseload, but can complement and support the work of hands-on employment advice services.

11.6 Student services

Mental health problems are common in student populations. IAPT services that are based in areas where there are higher education institutions should therefore develop assessment and treatment protocols to provide students with equitable access to treatment. Accessing treatment is likely to be complicated by the fact that many students reside in different areas during term-time and in the holidays. Features that are likely to help students benefit from their local IAPT services are:

- Close liaison between IAPT and student mental health services (some student welfare officers are unaware of the existence of IAPT services)
- IAPT staff being aware of the dates of student terms
- IAPT services having a policy of aiming to arrange assessment and the start of treatment for a student within the term that they are referred, unless the referral is close to the end of term. If the latter is the case, a risk assessment should be conducted and an alternative arrangement agreed with the student. That might involve arranging for IAPT or other treatment to start near the student's family home. Alternatively, it might involve agreeing to promptly start treatment when the student returns to college
- Liaison between IAPT and the GPs who are responsible for a student's care at different times of the year
- Protocols that allow treatment to continue both during and outside of term-time (perhaps using telephone or internet-based sessions).

12 Key features of a well-commissioned IAPT service

12.1 Principles underpinning the commissioning of IAPT services

The key commissioning principles that support best practice:

- **Right number of people seen**: understanding the level of need across local communities and maximising services to meet those needs[30]
- **Right services**: providing effective NICE-recommended treatments within a stepped-care framework, delivered by a sufficiently large, trained and competent workforce, and informed by patient feedback wherever possible
- **Right time**: improved access to services for people with depression and anxiety disorders, both in terms of people being treated and the waiting times they can expect from service providers
- **Right results**: collecting and delivering routine outcome data across the four domains of improved health and wellbeing, social inclusion and employment, improved choice and improved patient experience.

12.2 Key messages for commissioners

Commissioners should ensure that:

- For IAPT services to be successful there must be clear, credible, accountable and collaborative leadership in place, working closely with commissioners and other pathway leaders.
- Self-referral is available to promote access and facilitate a person's active attempts to seek help which can lead to improved outcomes.
- Communication and marketing is ongoing and collaborative. Commissioners should ensure there is a strategy in place that will bring together IAPT providers, primary care, other relevant providers, communities and patients to raise awareness of the service offer and promote access.
- There are targeted interventions for groups of people covered by the Equalities Act to promote wider access to IAPT.
- There is joint commissioning of high- and low-intensity interventions within IAPT so that there is a seamless transition for patients within the stepped-care model. Commissioning should also aim to develop coherent care pathways linking IAPT with other mental health provision.
- A highly responsive and accessible stepped-care model exists from primary care through to acute care, and that IAPT has a clear complementary fit within whole system pathways, through a well-defined IAPT service offer.
- Services are commissioned that can provide the right dose of treatment according to NICE guidelines and do not cap the number of sessions to less than NICE guidelines recommend. Evidence-based treatments should be given at the minimum dose that is necessary to achieve full and sustained recovery.
- The prices for service provision that are agreed between commissioners and providers should reflect the realistic cost of providing effective, evidence-based treatment for patients with varying service needs. Patients whose problems fall into higher mental health clusters will generally require more intensive treatment. The same applies to patients with PTSD and social anxiety disorder, as these are both conditions where NICE does not recommend low-intensity treatment as first choice options. A need to involve multiple professionals (for example, therapists and employment advisers) or to focus on the management of a LTC in addition to a mental health problem may also increase delivery costs.

- IAPT offers patients a choice of treatments and methods of delivery (digital or non-digital; individual or group), when NICE guidance indicates that multiple treatment options are effective.
- An appropriately trained and adequately sized workforce is in place, comprising PWPs, high-intensity therapists, employment advisers support staff, data and clinical leads. Practitioners in IAPT-LTC services should have had additional training for work with people who have LTCs or MUS.
- IAPT services provide an IAPT-compliant supervision system for all staff, access to appropriate CPD and a clear strategy for optimising staff wellbeing.

Commissioners should also:
- Consider IAPT service accreditation. For example, the Accreditation Programme for Psychological Therapies Services (APPTS) builds on the standards promoted by the National Audit of Psychological Therapies (NAPT). Services measuring against APPTS standards can identify areas of strength to share good practice, as well as areas to improve.
- Use a values-based commissioning approach to merge patient and carer perspectives, clinical expertise and evidence-based approaches when designing IAPT services.
- Use the opportunity presented by accountable care systems to collaboratively apply the commissioning cycle when planning IAPT service delivery, to develop a better shared understanding of local demographics, the patterns of service consumption and flow across health and social care services.
- Continuously and collaboratively monitor, review and refine local IAPT provision across the whole system pathway, especially during periods of wider service redesign that might impact on IAPT delivery.

12.3 Outcomes-based payment approach

NHS Improvement and NHS England have published guidance on Developing an Outcomes-based Payment Approach for IAPT Services. Services were required to adopt an outcomes-based payment approach from April 2018. Such an approach will better meet the mental health objectives of The Five Year Forward View and support commissioners and providers to better understand the resources needed to deliver the right care, in an effective and efficient manner.[31]

The guidance sets out one way to implement such an outcomes-based payment approach, but it is accepted that other ways may also be successfully adopted locally. NHS Improvement and NHS England will revise the guidance to reflect feedback from services, and publish examples of outcomes-based payment approaches that are being used by services. All approaches are expected to adhere to the following principles:
- recognise the severity of patient need and reflect this in the payment system
- reflect the cost of delivering evidence-based care in agreed prices
- link an element of payment to the 10 national quality and outcome measures.

12.4 A good IAPT service

Commissioning has a significant role to play in better performing services, ensuring the right level of investment and sensible contracting, monitoring and discussion of outcomes, and avoiding perverse incentives. The Care Quality Commission (CQC) assesses services against several specific domains (see Table 8) and it is good practice for commissioners and providers to work towards meeting the benchmarks set out within the CQC framework.

Table 8: Summary of what a good IAPT service looks like against CQC domains

CQC domain	Key features of a better performing IAPT service
Well-led	• **Effective leadership**: creating a culture of shared leadership through staff engagement, effective teamwork and accountability, with patients held firmly at the centre • **Values driven**: leaders displaying the values of the NHS through their behaviour, engaging stakeholders, delivering person-centred coordinated care and focus on staff wellbeing • **Clear strategic direction**: delivering an inspiring vision and alignment of objectives at every level • **Outcomes-focused**: ensuring a high-quality service providing the best possible standards of care for everyone in the local community • **Engage and empower others**: able to hold the key characteristics of the national IAPT programme while meeting local need within rapidly changing landscapes and working within the wider system to empower communities • **Value for money**: Focusing on productivity. Balancing effective, efficient service delivery with recovery focused compassionate care • **Building leadership capability**: Inspiring leadership development through promoting attendance at NHS leadership courses, IAPT regional leadership workshops and local leadership development forums • **Focus on innovation, research and the digital agenda**: to design service models that deliver best practice within evidence-based interventions and offer more choice, allowing staff to thrive within an innovation environment.
Effective	**The right therapy:** • A choice of evidence-based, NICE-recommended therapies based on accurate problem descriptors. For depression, the choice of therapies extends to beyond CBT approaches to include interpersonal therapy, brief psychodynamic therapy, couple therapy, and counselling for depression[4] • Following a prompt and good assessment, allocation to an appropriate low-intensity or high-intensity treatment. Progress should be carefully monitored with people being stepped up from low-intensity to high-intensity treatment if the initial response is inadequate. National data indicate that 37% of patients receive low-intensity treatment only, 29% receive high-intensity only and 34% have both.[32] This means that 71% of people have low-intensity treatment at some stage during their care episode and 63% receive high-intensity treatment at some stage in the care episode. However, there is considerable local variation in these figures • Services should have written good practice guidelines for staff to support clinical decision-making and appropriate stepping between treatments

	• **Session-by-session outcome measures** are a key characteristic of an IAPT service and provide an outcomes framework for performance management to drive quality improvement. This level of transparency helps commissioners to understand how effective the IAPT service is, as well as identify contracts that provide good value for money. **Meeting the national standards:** • Achieving recovery rates of at least 50% • Meeting the access standard set locally and the minimum national standard of 15% increasing to 25% by 2020/21 • Achieving the waiting time standard of 75% of people starting their course of treatment within 6 weeks of referral and 95% within 18 weeks • Minimum of 90% data completeness for pre/post-treatment scores for both depression and anxiety/MUS measures. **Best practice:** • At least two in three patients achieve reliable improvement • Most patients seen in the service go on to have a course of treatment (2 or more treatment sessions) • Problem descriptors are identified for at least 80% of patients who have a course of treatment • Most patients have their outcomes assessed with ADSMs or MUS measures, when the problem descriptor indicates that such measures are appropriate. **Continuous quality improvement:** • Data-informed service-level reflective practice. Curious about data, analysing themes and patterns and using this intelligence to improve outcomes • Local quality improvement strategies implemented, based on local areas of development identified through qualitative and quantitative data • Engaging staff and patients in shaping quality improvement • Improving equality of access and outcomes for all • Ensuring national reports reflect local performance through data quality validation including national and local data alignment • Research active and good relationships with local universities
Safe	**The workforce:** • Key focus on staff wellbeing • Appropriate number of trained staff • Appropriately qualified supervisors delivering outcomes-focused weekly supervision • Staff receive personalised feedback benchmarked against the service average or other clinicians • Tailored CPD • The right skills mix and level of experienced clinicians • A diverse workforce that reflects the local population and is culturally competent

	• Professional registration and accreditation • Workforce stability, retention and sustainability planning **Supporting safe therapy:** • Robust local systems that enable analysis of all outcomes, including reliable deterioration • Ensuring a good assessment to support the right evidence-based therapy is chosen in line with the accurate problem descriptor, using outcome measures, supervision and review as a corrective function **Integrated governance:** • This should be supported by effective data management systems that facilitate routine data collection and analysis. Data analysis should support timely feedback at an individual, clinician and service level, with service-level outcomes published • Performance management systems are important to ensure accountability, productivity and improving outcomes • Services should develop their own standard operating procedures to ensure data quality and validation (as local and national data must be aligned) • Local reporting capability is essential for reflective practice at individual, team and service level to promote a culture of enquiry • Local missed appointment policies and best practice guidance on attrition, as services should make strenuous efforts to assertively contact both new referrals and people that have lost contact during a treatment episode • Use of audit
Caring	**The person held firmly at the centre of care:** • Focus on holistic care with a commitment to empowering patients at the centre, to improve mental health and wellbeing, social inclusion and employment, improved choice and access and improved patient experience **Patient feedback and engagement:** • Individual feedback through completion of PEQs • Implementing changes and learning from feedback and complaints • Engagement in service design, service development and service improvement **Focus on staff wellbeing:** • A culture of shared and compassionate leadership providing high levels of support to staff • Clear objectives should be set for all staff, encouraging accountability and leadership at all levels • Development opportunities should be provided, accompanied by a high level of supervisory support • Provide and review training opportunities, tailored CPD and weekly outcomes-focused supervision • Special interest groups to enhance skills

	• Provide career development opportunities: senior PWP posts and lead PWP post
	• Team building to support effective teamwork
	• Wellbeing champions to promote wellbeing activities
Responsive	**Accessibility:**
	• Simple and direct access that is not hindered by complex patient opt-in or confirmation system
	• GP referral and self-referral, as demographics for self-referral are more representative of the local population
	• Seek to engage hard to reach groups to improve access and outcomes for all
	• Choice of location and able to offer home visits where appropriate
	• Clear and continuous publicity for the service to promote access: user-friendly and engaging websites, service leaflets, posters and other promotional materials developed and regularly updated
	Importance of choice: flexibility to fit with individual need
	• If treatments are similarly effective a choice of therapy should be offered in line with NICE guidelines
	• Choice of how therapy is delivered (one-to-one, group or blended therapy) where appropriate
	• Choice of gender, ethnic or cultural background, and/or religion of the clinician, where this is practical. The provider will ensure the client has access to an interpreter or BSL signer when necessary
	• Flexibility in terms of appointment times and location as well as contact via telephone, internet and email
	• have **built-in flexibility** around working times and when and where to offer additional appointments, such as weekend clinics
	Working with the wider system:
	Shaping integration within the wider system to improve a person's experience and outcomes at a local level.
	• Integration within primary care and GP champion
	• Links with other services, such as housing, debt, social care, third sector and charitable organisations
	• Employment advisers in the team to support individuals who are receiving treatment, and employment co-ordinators who work with employers to help people gain or retain employment
	• The services should offer psychological therapies for complex cases, but have the skills to identify when other support should be brought in
	• Connected, as part of a whole pathway approach, with the wider system, to facilitate a positive experience of care throughout

Annex

Position Statement on Staffing Standards in IAPT Services

1. Introduction

The IAPT manual sets out the framework for the staffing of IAPT services. This position statement provides further guidance on how this element of the Manual should be interpreted by services to safeguard the quality and governance of IAPT provision. In particular, it addresses specific requirements for training and accreditation.

2. IAPT Manual requirements for IAPT Workforce

The IAPT Manual[1] states:

'The right workforce, appropriately trained, with the right capacity and skills mix, is essential to ensuring the delivery of NICE-recommended care. Adherence to the protocols of NICE- recommended therapy is critical to good outcomes. Therefore, the success of the IAPT programme depends on the quality of the workforce.

All IAPT clinicians should have completed, or be currently undertaking, an IAPT-accredited training programme with nationally agreed curricula aligned to NICE guidance (or they should have acquired the relevant competences or skills before joining an IAPT service).
High-intensity therapists should be accredited by relevant professional bodies. All clinicians should be supervised weekly by appropriately trained supervisors.

The IAPT workforce consists of low-intensity practitioners and high-intensity therapists who together deliver the full range of NICE-recommended interventions for people with mild, moderate and severe depression and anxiety disorders, operating within a stepped-care model. National guidance suggests that approximately 40% of the workforce in a core IAPT service should be PWPs and 60% high-intensity therapists. For the new IAPT-LTC services it is recommended that there is a slightly stronger focus on high-intensity interventions with the workforce being 30% PWPs, 60% high-intensity therapists and 10% senior therapists (such as clinical and health psychologists) who have expertise in LTCs/MUS and can manage more complex problems as well as providing supervision to others.

Low-intensity workforce
PWPs deliver Step 2 low-intensity interventions for people with mild to moderate depression and anxiety disorders. All PWPs should have completed an IAPT training course, or be in the process of doing so. The core IAPT low-intensity courses for PWPs are accredited by the British Psychological Society. PWPs who work in the new IAPT-LTC services are also expected to have completed the relevant IAPT continuing professional development (CPD) course for working with LTCs and MUS.

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[1] https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-manual/

High-intensity workforce

High-intensity therapists deliver a range of Step 3 NICE-recommended evidence-based therapies, outlined in Table 3[2]. Therapists need to have been trained in the particular therapy or therapies that they deliver in IAPT, with linked professional accreditation with the relevant professional body. Commissioners and providers should ensure a choice of therapy is offered when NICE recommends several different therapy modalities for the same condition.'

3.   Training and Accreditation Requirements

3.1 Psychological Wellbeing Practitioners

3.1.1 Training Requirement for Entry

All Psychological Wellbeing Practitioners should have passed a British Psychological Society accredited PWP programme. If qualifying by the apprenticeship route they should in addition have passed the apprenticeship end-point assessment. Trainee Psychological Wellbeing Practitioners should all be currently registered as students on a BPS-accredited PWP Programme or on a PWP apprenticeship.

PWP Interventions should only be delivered by PWPs, trainee PWPs or High Intensity therapists who meet the criteria in this paper to deliver a high intensity IAPT intervention and have in addition demonstrated competence to deliver PWP interventions.

Training of PWPs outside of a BPS-accredited PWP programme is not recognised. Specifically, training in the Children and Young People's IAPT programme as a Children's Wellbeing Practitioner does not lead to competence as a PWP for adult IAPT, and is not transferable. Adult PWP training also does not equip a practitioner with competences to work in Children and Young People's IAPT.

There are currently no 'top-up' routes to PWP training that recognise prior learning. This means that all PWPs in Adult IAPT services need to pass the full PWP training on a BPS-accredited programme.**

3.1.2 Accreditation / Maintaining Competence

There is currently no individual PWP accreditation process, so entry by the training route outlined here is the only way to determine qualifying competence to undertake the role. In addition, PWPs should maintain and develop skills through regular continuing professional development as set out in the PWP Training Review (2015)[3] and the IAPT Guidance on Preceptorship and Continuing Professional Development for Psychological Wellbeing Practitioners, available on the HEE website.

3.2 High Intensity Therapists
3.2.1   Training Requirement for Entry
High Intensity Therapists working in IAPT Services should have EITHER:

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[2] Not reproduced here.

[3] https://www.ucl.ac.uk/pals/sites/pals/files/9_cpd_and_post-qualification_training.pdf

Completed the recognised IAPT qualification to deliver the therapy or therapies that they deliver in IAPT and gain and maintain the recognised individual accreditation to deliver these within one year of qualifying.

OR

(a) Have the recognised individual accreditation to deliver the therapy or therapies that they deliver in IAPT.

3.2.2 Accreditation / Maintaining Competence

High Intensity Therapists are expected to maintain continuous individual accreditation of the type set out in Table 1 that is relevant to the therapy or therapies that they provide in IAPT services. Accreditation serves two purposes: (1) it assures the public that core standards of professional and ethical behaviour have been adhered to by a practitioner and (2) it identifies practitioners with relevant competences to deliver particular psychological interventions. For some IAPT interventions an individual accreditation is necessary but not sufficient for purpose (2). In these cases, a specific IAPT training must be completed in addition to the accreditation. The practitioner is then expected to maintain competence in the specific IAPT intervention as part of the process of meeting their ongoing accreditation requirements. For example, an IAPT practitioner who has passed the IAPT Counselling for Depression training and is BACP Accredited is expected to include continuing professional development (CPD) activity to maintain competence in Counselling for Depression as part of their BACP CPD record.

3.3 Transitional Arrangements for staff without the required qualifications and accreditations

Where staff do not have the required qualifications and accreditations the clinical lead for the service will need to put in place transitional arrangements to ensure that the service is safe for patients and that the qualifications and accreditations of practitioners are transparent for the public using the service. A robust and urgent plan should be made to register staff onto the required training or for them to seek the required accreditations without delay. For patient safety it may be necessary to stop practitioners from practicing alone until they are registered as trainees or have their accreditation in place.

3.4 Other Roles

It is recognised that IAPT services may choose to employ clinical practitioners in addition to PWPs and High Intensity Therapists such as General Practitioners, Mental Health Nurses without a therapy qualification, and newer roles such as Associate Practitioners. IAPT services also employ non-clinical roles such as administrators and data analysts. No IAPT clinical assessments, PWP interventions or High Intensity Therapies can be provided by any of these roles without PWP or High Intensity training (completed or in process on a recognised IAPT course) and accreditation as set out in Table 1. However, some of the roles will be instrumental in making these therapies and PWP interventions as accessible and efficiently provided as possible.

Table 1: Recognised qualifications and individual accreditations for High Intensity Therapists in IAPT services

High-intensity therapy type	Explanation of NICE-recommended therapy type	IAPT training curriculum	IAPT training entry requirement	Training accredited by	Post-training Individual Accreditation Required	Practitioners must have the following to practice
Cognitive behavioural therapy (CBT)	A range of specialised CBT protocols for people with depression and anxiety disorders	Curriculum for High-Intensity Therapies Workers (IAPT CBT)	Core Profession or Knowledge Skills and Attitudes portfolio as outlined by the British Association for Behavioural and Cognitive Psychotherapies (BABCP)	BABCP (Level 2 accredited)	BABCP Accredited	Accredited IAPT CBT training and individual BABCP accreditation **OR** Individual BABCP accreditation alone achieved through training and experience with adults with anxiety and depression
Counselling for depression (CfD)	IAPT offers a particular type of counselling that has been developed for people with depression	Curriculum for Counselling for Depression (CfD)	British Association for Counselling and Psychotherapy (BACP) Accredited / United Kingdom Council for Psychotherapy (UKCP) Registered as a Psychotherapeutic Counsellor / Association of Christian Counsellors Accreditation / National Counselling Society Accredited Professional registrants	BACP	BACP Accredited / UKCP Registered as a Psychotherapeutic Counsellor / Association of Christian Counsellors Accreditation / National Counselling Society Accredited Professional registrants	Accredited IAPT CfD training and individual accreditation
Couple therapy for depression	Couple therapy can help people with their relationship and emotional difficulties that sometimes flow from problems between partners	Curriculum for Couple Therapy for Depression (CTfD) / Curriculum for Behavioural Couples Therapy (BCT) for Depression	BACP Accredited / UKCP Registered as a Psychotherapeutic Counsellor / BABCP Accredited / Association of Christian Counsellors Accreditation / National Counselling Society Accredited Professional registrants	Tavistock Relationships / British Association for Behavioural and Cognitive Psychotherapies	BACP Accredited / UKCP Registered as a Psychotherapeutic Counsellor / BABCP Accredited / Association of Christian Counsellors Accreditation / National Counselling Society Accredited Professional registrants	Accredited IAPT CTfD / BCT training and individual accreditation

4   The former (5 day) National Curriculum in Dynamic Interpersonal Therapy is a recognised qualification for DIT practitioners who started this training prior to 31 March 2020.

High-intensity therapy type	Explanation of NICE-recommended therapy type	IAPT training curriculum	IAPT training entry requirement	Training accredited by	Post-training Individual Accreditation Required	Practitioners must have the following to practice
Brief dynamic interpersonal therapy (DIT)	Brief psychodynamic psychotherapy developed for treating depression. It includes a focus on difficult things in the past that continue to affect the way people feel and behave in the present	Revised (20 day) Curriculum for High-Intensity Brief Dynamic Interpersonal Therapy (DIT) [4]	BACP Accredited / UKCP Registered as a Psychotherapeutic Counsellor / Association of Christian Counsellors Accreditation / National Counselling Society Accredited Professional registrants	British Psychoanalytic Council (BPC)	BACP Accredited / UKCP Registered as a Psychotherapeutic Counsellor / Association of Christian Counsellors Accreditation / National Counselling Society Accredited Professional registrants	Accredited IAPT DIT training and individual accreditation
Interpersonal Psychotherapy for depression (IPT)	IPT is a time-limited and structured therapy whose central idea is that psychological symptoms, such as depressed mood, can be understood as a response to current difficulties in relationships and affect the quality of those relationships	Curriculum for Practitioner Training in Interpersonal Psychotherapy (IPT)	BACP Accredited / UKCP registered as a Psychotherapeutic Counsellor / BABCP accredited/ General Medical Council registered Psychiatrist / HCPC registered practitioner psychologist or arts therapist / Association of Christian Counsellors Accreditation / National Counselling Society Accredited Professional registrants	Interpersonal Psychotherapy Network UK (IPT-UK)	IPT-UK Accredited at minimum of Level B	Accredited IPT training and individual accreditation (minimum Level B) **OR** Individual accreditation (minimum Level B)
Mindfulness-based cognitive therapy (MBCT)	A brief Psychological therapy specifically designed to prevent relapse in individuals with A history of recurrent depression. Treatment is often delivered in groups and starts after an initial intervention for an acute episode has been completed	Curriculum for Mindfulness-based Cognitive Therapy (IAPT MBCT)	BABCP Accredited	To be accredited by British Association of Mindfulness-based Approaches (BAMBA)	BAMBA listing of Mindfulness Teachers	Recognised IAPT MBCT Training and listed on BAMBA listing of Mindfulness Teachers **OR** listed on BAMBA listing of Mindfulness Teachers

** The only exceptions to this are individuals who completed the forerunner trainings in 2005–2008 at the University of York on which the national PWP curriculum was later based. Individuals may therefore be considered to have a recognised PWP training when they are:

1.	Graduates of the following programme with evidence of either MSc or PGCert award during the period 2005–2008:

University of York MSc in Mental Health Care (Primary Care Mental Health) [incorporating the Postgraduate Certificate in Mental Health Care (Primary Care Mental Health) for Graduate Primary Care Mental Health Workers].

OR

2.	Individuals who can evidence that they are holders of a valid certificate of competence from an in-service training provided by the University of York to the Doncaster Case Managers who worked in the Doncaster IAPT Pilot site in the period 2005–2008

Definitions of terms and abbreviations

Table 9: Definitions

Term	Definition
Accreditation	In the IAPT context, course accreditation with a recognised professional body indicates that the training programme has undergone a process of scrutiny to ensure that its curriculum, teaching materials, staffing, resources, management and governance structures have met the necessary national curricula requirements as agreed and laid down by the IAPT programme.
Caseness	A person is said to be at caseness when their symptom score exceeds the accepted clinical threshold for the relevant measure of symptoms. For the PHQ-9, this is a score of 10 or above. For the GAD-7, this is a score of 8 or above. Other symptom measures, such as those used to measure the severity of different anxiety disorders, have their own specific thresholds. Some outcome measures (such as the WSAS) do not have recommended caseness thresholds but provide valuable additional information about the quality of a treatment response.
Long-term physical health conditions (LTCs)	A range of long-term physical health conditions such as cardiovascular disease, chronic obstructive pulmonary disease, diabetes and musculoskeletal disorders.
Medically unexplained symptoms (MUS)	Persistent physical symptoms that are distressing and disabling but cannot be wholly explained by a known physical pathological cause. Examples include chronic fatigue syndrome and irritable bowel syndrome.
Problem descriptor	A way of describing a person's presenting mental health problems as assessed by an IAPT service (previously referred to as a 'provisional diagnosis'). The descriptor corresponds with ICD-10 codes and captures information on the nature, severity and duration of symptoms, and their impact on functionality. A problem descriptor is used to support identification of appropriate NICE-recommended treatment options. It is recognised that people may have more than one mental health problem. For this reason, services can enter several problem descriptors. The primary problem descriptor should reflect the treatment being delivered.
Recovery	A national standard that at least 50% of eligible referrals should move to recovery has been set for IAPT services. A person moves to recovery if their symptoms were considered a clinical case at the start of their treatment (that is, their symptoms exceed a defined threshold as measured by scoring tools) and not a clinical case at the end of their treatment.
Reliable improvement	A person has shown reliable improvement if there is a significant improvement[m] in their condition following a course of treatment, measured by the difference in their first and last score.
Reliable recovery	A person has 'reliably recovered' if they meet the criteria for both recovery and reliable improvement.

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[m] As such the difference in scores is not attributed to chance.

Stepped-care services:	
Step 1	Primary care
Step 2	Low-intensity service: less intensive clinician input, includes guided self-help and computerised CBT
Step 3	High-intensity service: usually weekly face-to-face, one-to-one sessions with a suitably trained therapist, also includes CBT group work or couple therapy for depression.

Table 10: Abbreviations

ADSM	Anxiety disorder specific measure
APMS	Adult Psychiatric Morbidity Survey
BAME	Black, Asian and minority ethnic
BIQ	Body Image Questionnaire
CBT	Cognitive behavioural therapy
CCG	Clinical commissioning group
COPD	Chronic obstructive pulmonary disease
CPD	Continuing professional development
CQC	Care Quality Commission
DSM-5	Diagnostic and Statistical Manual of Mental Disorders
GAD-7	Generalised Anxiety Disorder Scale – 7 items
GP	General practitioner
HAI	Health Anxiety Inventory
IAPT	Improving Access to Psychological Therapies
IAPT-LTC	IAPT services for people with long-term physical health conditions and medically unexplained symptoms
IBS	Irritable bowel syndrome
IPT	Interpersonal psychotherapy
LTC	Long-term physical health condition
MBCT	Mindfulness-based cognitive therapy
MDS	Minimum Data Set
MI	Agoraphobia-Mobility Inventory
MUS	Medically unexplained symptoms
NCCMH	National Collaborating Centre for Mental Health
NICE	National Institute for Health and Care Excellence
OCD	Obsessive-compulsive disorder
OCI	Obsessive-Compulsive Inventory
PCL-5	PTSD Checklist for DSM-5
PDSS	Panic Disorder Severity Scale
PEQ	Patient Experience Questionnaire
PHQ-9	Patient Health Questionnaire – 9 items
PHQ-15	Patient Health Questionnaire – 15 items
PTSD	Post-traumatic stress disorder
PWP	Psychological wellbeing practitioner

RCT	Randomised controlled trial	
SPIN	Social Phobia Inventory	
WSAS	Work and Social Adjustment Scale	79

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