

Improving Access to Psychological Therapies (IAPT) Commissioning Toolkit

Care Services Improvement Partnership 

National Institute for
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Improving Access to Psychological Therapies (IAPT) Commissioning Toolkit

**Developed in partnership with
NHS Commissioners**

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1. Introduction

- 1.1 The Improving Access to Psychological Therapies (IAPT) programme has one principal aim – to help primary care trusts (PCTs) implement National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders. At present, only a quarter of the 6 million people in the UK with these conditions are in treatment, with debilitating effects on society.¹
- 1.2 The programme is improving health and well-being, promoting social inclusion and improving economic productivity. In 2007, 13 pilot sites around the country began to demonstrate the programme's benefits, alongside existing psychological therapies services operating in primary care. Routine collection of outcome measures demonstrated effectiveness and service excellence.
- 1.3 The Government is committed to improving access to psychological therapies and announced additional funding to increase services over the next three years,² which will be phased as the workforce to deliver these services is trained. Between 20 and 40 PCTs will receive funding in the first year, 2008/09. The IAPT Implementation Plan³ provides more detail.
- 1.4 The Comprehensive Spending Review 2007 allocated IAPT:
 - £33 million in 2008/09;
 - a further £70 million to a total of £103 million in 2009/10; and
 - a further £70 million to a total of £173 million in 2010/11.
- 1.5 Improving access to psychological therapies is the subject of a Public Service Agreement between the Department of Health and the Treasury. It is also a Vital Sign in the *NHS Operating Framework 2008/09*.

¹ Psychiatric Morbidity Survey (2000)

² www.gnn.gov.uk/environment/fullDetail.asp?ReleaseID=321341&NewsAreaID=2&NavigatedFromDepartment=True

³ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083150 (see also the IAPT Impact Assessment on the same web page)

In 2008/09 the IAPT Programme will support the implementation of stepped-care psychological therapies (as recommended by NICE) in 20 sites across all SHAs. To prepare for these services being available more widely in future, PCTs should begin planning how they will implement a stepped-care psychological therapies service, supported by best practice guidelines. The first step will be to carry out a needs assessment of their local population, to understand what level of services will need to be provided.

NHS Operating Framework 2008/09

- 1.6 This toolkit is designed to help PCTs improve or establish stepped-care psychological therapies services following NICE guidelines. It is intended for **all** PCTs, whether or not they will receive additional national funds in the initial stages of the programme, to help them prepare to do so. It brings together a wide range of existing tools and guides in the Annex, including the NICE commissioning guide on cognitive behavioural therapy (CBT) for common mental health problems.⁴ We will review and update the toolkit as IAPT implementation progresses, with a first review in September 2008 when the first year's PCTs start delivering services.
- 1.7 Commissioners are important local leaders in delivering new psychological therapies services, promoting health and well-being through strong partnerships with professionals, local government, employment services, people who use services and those who support them. This programme gives them an opportunity to collaborate with providers from all sectors to find genuinely innovative ways of meeting local people's needs and demonstrate they are doing so through routine collection of outcomes data.

⁴ NICE Commissioning Guides, *Mental Health and Behavioural Issues*, in development, due 2008. For information visit: www.nice.org.uk/usingguidance/commissioningguides/commissioning_guides_8211_supporting_clinical_service_redesign.jsp

Rita's story

I grew up in a very dysfunctional house, suffering years of child abuse, convinced it was all my fault. I moved to another continent to start a new life but had a series of relationships with abusers, including a 20-year marriage to a specialist in verbal and emotional abuse. I left with nothing but my freedom and life was bleak for a long time. I became increasingly depressed and cripplingly anxious.

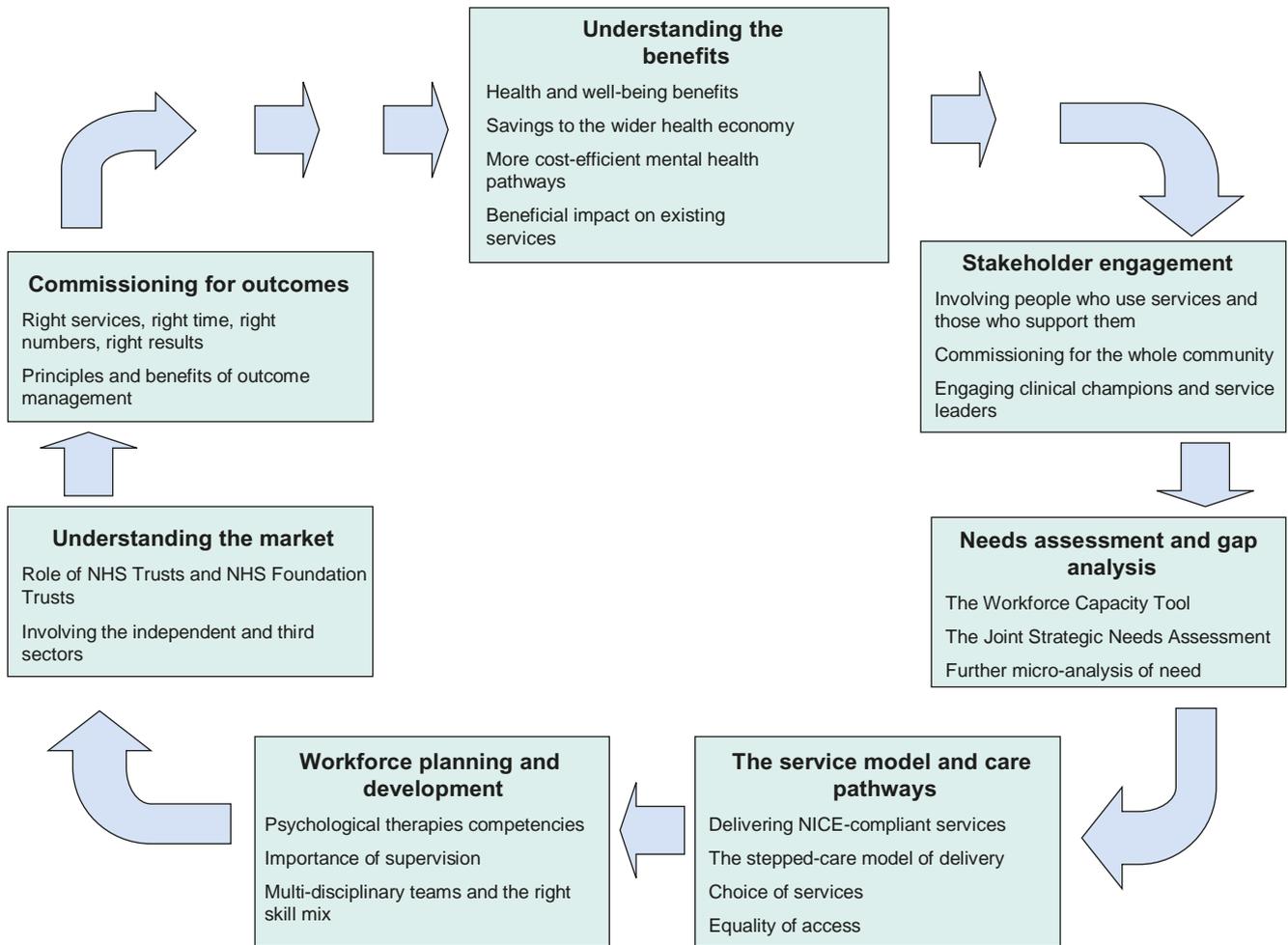
One day, my GP showed me a leaflet on CBT. I needed to recover without pills and knew I needed help. I read the books the psychologist gave me and, seeing myself in the text, began to understand my condition. The homework was crucial. As I completed the charts, I could see clearly the patterns I had repeated throughout my life.

What really changed my perspective was my therapist pointing out successes where I had seen none. I realised ideas I had about myself were just plain wrong, drilled into me by people with their own agenda and their own desires for control. I had irrefutable evidence that I was (and am) far more than I ever thought I was. My depression began to lift and I began to heal – a slow, ongoing process. I still get depressed but it doesn't immobilise me thanks to the tools my therapist taught me.

- 1.8 The toolkit is structured around the commissioning cycle illustrated in Figure 1. It includes positive practice examples throughout and is specifically linked to the World Class Commissioning competencies.⁵

⁵ www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/index.htm

Figure 1: Psychological therapies commissioning cycle



2. Understanding the benefits

World Class Commissioning competencies:

- **Locally lead the NHS** – Applying the NHS values – fair, personal, effective and safe – to strategic planning and decision making.
- **Work with community partners** – Working collaboratively with partners, PCTs will stimulate innovation, efficiency and better service design, increasing the impact of the services they commission to optimise health gains and reduce health inequalities.

- 2.1 Mental ill health is Britain's biggest social problem.⁶ Depression and anxiety disorders are serious conditions and have a major impact on how well an individual is able to function. A recent World Health Organization study concluded that the impact of depression on a person's functioning was 50% more serious than angina, asthma, diabetes and arthritis.⁷ At present, 40% of disability is due to depression and anxiety.⁸
- 2.2 Commissioning psychological therapies can improve people's health and well-being (including those with long-term conditions), leading to savings for the wider health economy and more cost-efficient mental health care pathways. The IAPT programme is not intended to fund all the psychological therapies needed but to increase the amount of therapies available and the expenditure on mental health care.
- 2.3 PCTs have an opportunity to map existing psychological therapies services, review their effectiveness (including cost-effectiveness) and build on and complement them, whether they are provided by the statutory, third or independent sector. While it is the duty of commissioners to ensure service efficiencies, this should not be funded by inappropriate cuts in other mental health services.

⁶ The Centre for Economic Performance's Mental Health Policy Group, 2006, *The Depression Report: A New Deal for Depression and Anxiety Disorders*, London School of Economics and Political Science

⁷ Moussavi S, Chatterji S, Verdes E et al, 2007, Depression, chronic diseases, and decrements in health: results from the World Health Surveys, *The Lancet*, 370: 851–8

⁸ Psychiatric Morbidity Survey, 2000

2.4 The distinction between primary and secondary care can be reduced by creating a single system that provides for almost all the psychological treatment needs of people with depression and anxiety disorders. Commissioning such comprehensive and integrated care pathways can avoid undue delays between steps, provide more treatment near people's homes and take account of the needs of those with more complex, chronic and co-morbid disorders.

Health and well-being benefits

2.5 Despite the prevalence of depression and anxiety disorders and the fact that mental health problems account for nearly 40% of people on incapacity benefit and a third of all GPs' time, only a third of people with diagnosable depression and less than a quarter of those with anxiety disorders are in treatment.

2.6 NICE recognises psychological therapies as effective and safe treatments, both in the short term, and for preventing relapse in the longer term. It recommends a range of psychological therapies, including CBT, for mild to moderate depression and anxiety disorders. The IAPT Demonstration Sites⁹ and other psychological therapies services¹⁰ have demonstrated impressive health and well-being gains.

IAPT Demonstration Sites

The two national IAPT Demonstration Sites in Doncaster and Newham showed:

- impressive recovery rates broadly in line with NICE's evidence from clinical trials;
- improved recording of treatment outcomes (90%);
- significant achievements helping people off statutory sick pay and back into work, education or training;
- large numbers of people being treated in a short timeframe; and
- previously unidentified and unmet need being met by inviting self-referral – in Newham, people accessing the service themselves were often just as ill and, in some cases, had more chronic conditions than those referred by their GP.

⁹ LSE Economic Evaluation, in development, due spring 2008

¹⁰ *Counselling and Psychotherapy Research* Vol 6, No 1, March 2006

Potential savings for the wider health economy

- 2.7 Providing psychological therapies to people who can benefit from them can help commissioners deliver greater efficiencies to the local health economy. A review of 91 studies showed that implementing psychological interventions achieved average savings of 20%¹¹ including immediate efficiency gains, most significantly by reducing medical outpatient appointments and treating people with long-term conditions.
- 2.8 Studies of medically unexplained symptoms (MUS) show that between 20% and 30% of those seen in primary care have no clear diagnosis. In secondary care, this rises to an average of 52%.¹² Some estimates place the cost of these cases at an average of £955.¹³

Psychological therapies and medically unexplained symptoms

John's practice, with five GPs, was heavily burdened with patients with unexplained symptoms, with one partner spending about 10% of her time consulting with a relatively small number of frequent attenders. The frequently consulting patients were invited by letter to a longer consultation, at which they were reassessed, and then offered referral to the local psychological therapies service, once the GP was happy that no new physical illness had been missed. Half of the patients attended, and then accepted referral. Some months later, the psychological therapies team reported progress with the patients and the practice reported a substantial reduction in attendance from this group of people.

- 2.9 Psychological therapies services can improve health and well-being and, at the same time, lead to significant savings by improving people's ability to manage their long-term physical conditions, such as diabetes and heart disease, through the positive management of their mental health.¹⁴ Studies suggest that depression is associated with a 50% increase in the costs of long-term medical care.¹⁵

¹¹ Chiles JA, Lambert MJ and Hatch AL, 1999, The impact of psychological interventions on medical cost offset: A meta-analytic review, *Clinical Psychology: Science and Practice*, 6: 204–220

¹² Nimnuan C, Hotopf M, and Wessely S, 2001, Medically unexplained symptoms: an epidemiological study in seven specialities, *Journal of Psychosomatic Research*, 51: 361–7

¹³ Reid S, Wessely S, Crayford T and Hotopf M, 2002, Frequent attenders with medically unexplained symptoms: service use and costs in secondary care, *British Journal of Psychiatry*, 180: 248–53

¹⁴ Department of Health, 2007, *Commissioning a brighter future: improving access to psychological therapies – positive practice guide*, DH

¹⁵ Katon W, 2003, Clinical and health services relationships between major depression, depressive symptoms, and general medical illness, *Biological Psychiatry*, 54(3): 216–26

2.10 Effective primary care helps achieve these cost improvements by playing a full part in a stepped-care system. Training for staff is essential to enable detection, early treatment, signposting and follow-up. NICE is producing guidance in 2008 on the co-morbidity of depression with long-term conditions.¹⁶

Psychological interventions and physical illness

Some examples of potential health, well-being and economic gains that psychological interventions offer people with physical illness:

- The Hillingdon chronic obstructive pulmonary disease (COPD) trial saved £70,000 over six months, by investing £25,000 a year in CBT.
- An estimated 40% of hospital admissions and half of revascularisations can be avoided by providing CBT-based education to those suffering with refractory angina.¹⁷
- Among those with diabetes, depression is associated with a 50% to 75% increase in health service cost.¹⁸
- In primary care, Gill et al have shown that 13.8% of all consultations were with 'frequent consulters'. (see paragraph 2.10)¹⁹
- Martin et al have shown that providing psychological therapies for those suffering with MUS produced a reduction of 50% in GP visits by these patients.²⁰
- Morley et al said 'Diverse studies showed that CBT was effective in reducing pain experience, and improving positive behaviour expression, appraisal and coping in individuals with chronic pain.'²¹

¹⁶ www.nice.org.uk/guidance

¹⁷ www.angina.org/ and www.primarycarecontracting.nhs.uk/eventmanager/uploads/dr_michael_chester.ppt

¹⁸ Simon G, Katon W, Lin E et al, 2005, Diabetes complications and depression as predictors of health service costs, *General Hospital Psychiatry*, 27: 344–51

¹⁹ Gill D, Dawes M, Sharpe M and Mayou R, 1998, GP frequent consulters: their prevalence, natural history, and contribution to rising workload, *British Journal of General Practice*, 48: 1856–7

²⁰ Martin A, Rauh E, Fichter M and Rief W, 2007, A one-session treatment for patients suffering from medically unexplained symptoms in primary care: a randomized controlled trial, *Psychosomatics*, 48: 294–303

²¹ Morley S, Eccleston C and Williams A, 1999, Systematic review and meta-analysis of randomised controlled trials of cognitive behaviour therapy and behaviour therapy for chronic pain in adults, excluding headache, *Pain*, 80: 1–13

More cost-efficient mental health-care pathways

- 2.11 Expanding psychological therapies services to meet existing need is likely to change local mental health care pathways and reduce:
- 'inappropriate' referrals to secondary mental health care services (such as community mental health teams); and
 - secondary care assessment time.
- 2.12 Offering effective treatments in the initial stages of an individual's care pathway may reduce the number of people referred to more specialist services, as well as long waits and multiple assessments. This will allow the more specialist services to focus on meeting the needs of their service users more effectively.
- 2.13 Commissioners' negotiations with service providers about implementing psychological therapies and the additional investment in IAPT should increase capacity for primary care-based mental health services and balance this with redesigned and more effective secondary care services. Service reconfiguration may allow secondary care services greater capacity and flexibility in their core business.
- 2.14 The initiatives that underpin New Ways of Working²² (NWW) can help commissioners determine how such changes in their local systems will enhance the care pathway. For example, commissioners may review the role traditional outpatient clinics play in their commissioning plans, depending on how they see psychological therapies services affecting the number of people being assessed and followed up in this way in the future. NWW for applied psychologists also offers flexibilities.
- 2.15 In developing psychological therapies services, commissioners and their Practice Based Commissioning (PBC) groups may consider how existing primary care counselling services can be integrated into stepped-care psychological therapies services and what impact these services are likely to have on prescribing costs. The IAPT Workforce Capacity Tool²³ can compare estimated costs for selective serotonin reuptake inhibitors (SSRIs) and PCT expenditure and thus indicate what prudent prescribing, along with psychological therapies, can achieve over time.

²² www.newwaysofworking.org.uk

²³ www.mhchoice.csip.org.uk/psychological-therapies/workforce/workforce-capacity-tool.html

- 2.16 It will be helpful to review the services that are currently available, including counselling services, to ensure that their current role is understood and gaps in services are identified. Counsellors are an important source of IAPT workforce supply, and so it will be helpful to offer additional training to enable them to deliver the broader range of psychological therapies.
- 2.17 All the issues raised in this section have a financial value. Commissioners may review these factors and consider how each aspect might be incorporated in their psychological therapies commissioning plans.

Margaret's story

Margaret was in her early 40s when she was referred to her local community mental health team by her GP following a relationship breakdown. At an initial assessment, a consultant psychiatrist identified an apparent moderate depressive episode and she was placed on a waiting list to be seen as an outpatient. Margaret was seen in the outpatient department four weeks later. The senior house officer noted no improvement and increased her medication. Margaret was keen to access talking therapies but this was not offered because of long waiting times for such services locally.

In the absence of psychological therapies services being available, Margaret was offered routine follow-up as an outpatient; however, she rarely saw the same clinician twice and because of this began to miss appointments. After one year of sporadic engagement, Margaret was discharged back to her GP by secondary mental health services.

At this point, Margaret was referred to the new psychological therapies team which again assessed her as suffering from a moderate depressive episode. After only two sessions with the team's link worker, Margaret showed considerable improvement on her scores in the Depression Module of the Patient Health Questionnaire (PHQ9) and General Anxiety Disorder Module of the Patient Health Questionnaire (GAD7). Margaret had two further contacts with the team, which assisted her with a self-help programme through the local books on prescription scheme, and after four appointments over one month, she was discharged having effectively completed treatment.

3. Stakeholder engagement

World Class Commissioning competencies:

- **Engage with public and patients** – Proactively seeking out the voices and experiences of the public, patients, their carers and other stakeholders, especially those least able to act as advocates for themselves.
- **Collaborate with clinicians** – Ensuring that, through the involvement of clinicians in strategic planning and service design, commissioned services build on the current evidence base, maximise local care pathways and utilise resources effectively.
- **Work with community partners** – Considering the wider determinants of health and the role of other partners in improving the health outcomes of their local population.

- 3.1 Meaningful involvement that gathers the views of people who use psychological therapies services and those who care for them requires time and investment. A number of voluntary sector mental health organisations and service user-led groups offer clear guidance on how to do this well.²⁴
- 3.2 Psychological therapies services treat millions of people each year who find themselves in mental distress and it is vital that the often discriminating effects of using mental health services are minimised and the services regarded as normal.
- 3.3 To ensure equity of access, people using psychological services and those who support them need to:
 - be well informed;
 - have choices about what exists in their local area;
 - be clearly signposted to services that best fit their needs; and
 - know how to give feedback about the quality of the services they have received.

²⁴ www.nsun.org.uk, www.together-uk.org, www.mhf.org.uk, www.mhpf.org.uk

- 3.4 Professionals need to recognise that people who support individuals in mental distress may have support needs that are very different from the person using the services. Carers may also need time to talk about how the mental ill health of a family member or friend has affected their lives. Details of local and national carers support organisations are available through Carers UK.²⁵
- 3.5 People using services should not be categorised simply by their distress or diagnosis. The whole person needs to be considered. Access to careers advice, job search, healthier lifestyles (food and exercise) and appropriate training could be central to a person's recovery and can be provided at any stage in the stepped-care model (see Figure 2 in Section 5) so that individuals get the greatest benefit from the psychological intervention.
- 3.6 Commissioners should be aware of people's common complaints about the information they receive. It often:
- is not available in the places they frequent;
 - uses medical jargon and can be difficult to understand; and
 - is not provided with enough time for people to digest it and ask questions that would help their decision making or clarify their thinking.
- 3.7 The Patient Information Toolkit²⁶ provides advice on producing information about services, and includes a checklist on page 14 outlining what to include. Booklets for people who use psychological therapies, describing the skills they can expect their therapists to have, may be useful.²⁷

²⁵ www.carersuk.org

²⁶ www.nhsidentity.nhs.uk/patientinformationtoolkit/patientinfotoolkit.pdf

²⁷ www.mhchoice.csip.org.uk/silo/files/cbt-what-skills-can-service-users-expect-their-therapists-to-have.pdf

Blue's story

I have suffered from depression for 22 years, with chronic anxiety, insomnia and panic attacks from time to time, and a debilitating physical condition for the last three years. At 19, I was in a happy relationship and full-time employment but felt isolated and unable to discuss how I felt.

Medication exacerbated my state. Over the years, I made new friends and was able to talk about things but still felt very much alone with my illness. A series of bad events in my life led me to seek out counselling but once it ended I again felt alone and without direction. I tried several antidepressants prescribed by my doctor but they often left me feeling confused.

At 40, I was offered a new service being piloted in my area and agreed to a course of CBT. Within a year, I achieved the objectives set out in my first session. I am more confident within myself and have more control of the direction of my life, taking steps to get back to work and involved in various projects as co-chair of Newham Psychological Treatment Centre Service Users Panel.

Commissioning for the whole community

- 3.8 The personal and economic costs of mental ill health affect all parts of society and it is important to offer psychological intervention to everyone who will benefit from it.
- 3.9 The Government's Comprehensive Spending Review 2007 investment is enabling IAPT services to start being established across the country. More work is needed if these services are to meet the needs of the whole population and to demonstrate positive outcomes for all sections of society. The Department of Health has established a number of working groups which are looking at various special interest group workstreams, including:
- issues of engagement, access and appropriateness faced by people from different communities and people with a range of needs;
 - work with children and young people – the relationship between different commissioners, synergies with local authorities and Department for Children, Schools and Families policy;
 - treatment of offenders with common mental health problems;
 - perinatal care;

- the relationship between treating common mental health problems and managing long-term conditions such as diabetes, COPD and ischaemic heart disease;
- examining the impact of psychological treatment on people with MUS being seen in primary care;
- work with older people – helping to join together existing initiatives; and
- how elements of IAPT services may be appropriate for people who have experienced trauma – important in developing civil contingency planning.

3.10 The workstreams above will focus on developing service models, care pathways and outcome measures appropriate for these different communities. They will also produce short Commissioning Positive Practice Guides²⁸ giving ‘top tips’ on commissioning services for those specific communities.

3.11 Some people, including those from black and minority ethnic communities, find that traditional psychological therapies do not always meet their needs. Commissioning a balanced portfolio of clinically effective psychological therapies is key to promoting equity of access. This may involve creating dedicated and specific services targeting particular groups. Services provided by voluntary and community groups are often thought to be more valuable, and PCTs should consider this when making commissioning decisions.

3.12 Research indicates that large variation in equity of psychological therapies services provision is likely.²⁹ It is important that everyone in the population has an equal opportunity to access psychological therapies. When planning services, steps must be taken to eliminate discrimination and promote equality of opportunity and good relations between different groups of people. Equality legislation obliges PCTs to carry out Equality Impact Assessments³⁰ on their local plans.

²⁸ www.mhchoice.csip.org.uk

²⁹ Barnes D, Hall J and Evans R, 2008, The shape of psychological therapy services in primary care, *Healthcare Counselling and Psychotherapy Journal*, 8(2): 19–23

³⁰ See the IAPT Equality Impact Assessment Screening Phase at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083150

3.13 Ways of ensuring equal access include providing:

- equality and diversity awareness and competency training to staff;
- advocates and/or interpreters;
- information in a variety of formats and languages;
- services in a culturally relevant format accessible to local populations; and
- locally commissioned services in a variety of community-based, non-stigmatising, culturally sensitive settings.

3.14 A recent good practice guide on IAPT, published as a result of NWW for applied psychologists, provides some positive practice examples of how access to psychological therapies can be enhanced for these other groups.³¹

3.15 The Department of Health has commissioned an IAPT Equalities Toolkit,³² which will be available in spring 2008 to aid PCTs in undertaking Equality Impact Assessments, and planning service delivery that meets the needs of the whole population.

³¹ [www.newwaysofworking.org.uk/pdf/Improving%20Access%20\(IAPT\).pdf](http://www.newwaysofworking.org.uk/pdf/Improving%20Access%20(IAPT).pdf)

³² www.mhchoice.org.uk

Mental health problems can affect the whole community

- Over 1,300,000 **older people** have depression and mental illness and this number is expected to increase over the next few years as the population ages.³³
- One in ten **new mothers** suffer from postnatal depression of which, a recent Mind report suggested, less than one in five receive psychological treatment. In England, this equates to around 30,000 women each year.³⁴
- Around 700,000 **children and younger adults** (one in ten³⁵) in England and Wales have a reported mental health condition. Not treating problems early can lead to anti-social behaviour and poor educational attainment. This costs the child in lost opportunities and society the cost of looking after them. For instance, childhood conduct disorders cost the economy in excess of £3,000³⁶ per year per child and this escalates to £70,000 as the young person reaches adulthood.³⁷
- Of the 7 million **carers** in Britain, one in five females and one in ten males report mental illness.³⁸
- Large numbers of people develop psychological problems **as a result of physical illness or disability**. For example, up to 40% of people with Parkinson's disease³⁹ have depression.

³³ Banerjee S, 2007, Socio-economic impact of older people's mental health (private correspondence with Professor Ian Philp)

³⁴ There were 613,028 births in England in 2005 (Office for National Statistics, Table 7.1 Live births (numbers, rates, general fertility rate, and total fertility rate), and population: occurrence within/outside marriage, and area of usual residence, 2005). The Royal College of Psychiatrists suggests that one in ten women have postnatal depression

³⁵ Meltzer H, Gatward R, Goodman R and Ford T, 2000, *The mental health of children and adolescents in Great Britain*, HMSO

³⁶ Romeo R, Knapp M and Scott S, 2006, The economic cost of severe antisocial behaviour in children – and who pays it, *British Journal of Psychiatry*, 188: 547–53

³⁷ Scott S, Knapp M, Henderson J and Maughan B, 2001, Financial cost of social exclusion: follow up study of antisocial children into adulthood, *British Medical Journal*, 323: 191

³⁸ Office for National Statistics/Department of Health, 2002, *Mental Health of Carers*

³⁹ Parkinson's Disease Society, 2006, Depression and Parkinson's information sheet, page 2, www.parkinsons.org.uk/pdf/is_fs56_depression_06.pdf

4. Needs assessment and gap analysis

World Class Commissioning competencies:

- **Manage knowledge and assess needs** – Making commissioning decisions based on sound knowledge and evidence, ensuring that current and future commissioned services address and respond to the needs of the whole population, especially those whose needs are greatest.
- **Prioritise investment** – Setting strategic priorities with partners and making investment decisions focused on the achievement of key clinical, health and community outcomes, including investment plans that address the areas of greatest health inequality.

- 4.1 Health needs assessment is an essential tool for service planning. In this context, need is defined as the ability to benefit from health and social care support and intervention. Needs must be assessed at both an individual and population level to ensure that services fit the requirements of the person accessing the service and to contribute to a fuller understanding of need in a local population.
- 4.2 This section describes tools that can help commissioners assess the need for psychological therapies, map existing service provision, identify gaps and integrate this into a Joint Strategic Needs Assessment (JSNA).

The IAPT Workforce Capacity Tool

- 4.3 The Workforce Capacity Tool⁴⁰ can be used as the basis of a needs assessment for psychological therapies. It helps estimate the likely prevalence of common and severe mental health conditions for a given population (PCT or PBC cluster). It then uses best practice care pathways to estimate the workforce likely to be needed to deliver care for the specified population (see Section 6 on workforce planning).
- 4.4 The tool provides an indicative assessment of need and should be considered in the context of existing service availability. PCTs should vary the assumptions in the tool's blue boxes in line with their local services and plans. It is important to remember that the new IAPT investment is intended to fund additional psychological therapies, not to replace any funding that PCTs have already been making available for these services.

⁴⁰ www.mhchoice.csip.org.uk/psychological-therapies/workforce/workforce-capacity-tool.html

- 4.5 The tool derives need from survey data⁴¹ and applies corrections for deprivation, presentation and diagnosis. It then applies evidence-based treatments (based on NICE guidelines) to calculate the required numbers of treatment sessions and workers, and the medication required.
- 4.6 Commissioners can alter many of the assumptions, to model changes in service provision and the impact on costs assessed. This approach allows commissioners to specify treatment pathways for each disorder in their locality. The work should involve an analysis of existing psychological therapies services, including voluntary and other independent sector provision.⁴²
- 4.7 Commissioners should consider involving current and potential providers in the needs assessment (at both population and individual level) and in planning how to address identified need. The planning should include reviewing the range of providers best able to meet the needs of the community and considering how best to incentivise providers to improve or meet gaps in current service provision.
- 4.8 The Workforce Capacity Tool has a number of other functions, including:
- calculations for smaller populations such as PBC groups, which can directly input the population they are interested in;
 - estimates of how many computerised CBT (cCBT) licences localities require;
 - examples from the IAPT Demonstration Sites at Newham and Doncaster illustrating how altering the care pathway and service structure affects the number of staff required and service costs;⁴³ and
 - estimates of need and consequent mental health services required by the National Service Framework for Mental Health.
- 4.9 More information can be found in *The Workforce Capacity Tool: A Guide for Users*.⁴⁴

⁴¹ Psychiatric Morbidity Survey, 2000

⁴² Barnes D, Hall J and Evans R, 2008, The shape of psychological therapy services in primary care, *Healthcare Counselling and Psychotherapy Journal*, 8(2): 19–23

⁴³ Initially Newham was mainly a 'face-to-face high-intensity' service, with a lower throughput of patients, whereas Doncaster was a 'mainly telephone low-intensity service', with a much higher throughput of patients

⁴⁴ www.mhchoice.csip.org.uk

The Joint Strategic Needs Assessment

- 4.10 Local authorities and PCTs have a new duty to undertake a JSNA⁴⁵ from 1 April 2008. Findings from an assessment of need for psychological therapies should be integrated into the JSNA so that strategic links can be made with other parts of the local health and social care economy. This might include meeting the 18 weeks target for acute care, improving the health and well-being of people with long-term conditions and introducing a more evidence-based approach to SSRI prescription.
- 4.11 The JSNA examines aggregated assessment of need. It is a tool to identify groups where needs are not being met and that are experiencing poor outcomes. It aims to understand needs over the next three to five years, taking into account improvements in outcomes and reductions in health inequalities. It focuses on prevention, stimulating a shift in investment towards keeping people well and independent in their own homes and communities and actively engaging with people to develop a full understanding of needs.
- 4.12 The key focus of a JSNA is on improving health and well-being outcomes, in particular those described in the National Indicator (NI) set. This includes a number of indicators relevant to psychological therapies that sit outside the set's health section, including:
- children living in poverty (worklessness is a major cause of child poverty, NI 116); and
 - people falling out of work and onto incapacity benefits (NI 173).
- 4.13 Commissioners may want to consider how investment in psychological therapies will contribute to good performance on a range of indicators identified in their JSNA and Local Area Agreement as a means of drawing in human and financial resources and encouraging closer working with, for example, employment services.

Further micro-analysis of need

- 4.14 It may be necessary to carry out further micro-analysis of need to identify any groups in the community with specific needs. This is likely to include those community groups covered by the IAPT Special Interest Groups (see paragraph 3.9), such as black and minority ethnic communities and older people.

⁴⁵ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097

Micro-analysis of need – Stoke-on-Trent PCT

Stoke-on-Trent is in the poorest 10% of local authorities in England in terms of deprivation, ranked 33 out of 352 in terms of multiple deprivation (352 being the best). There are considerable variations in the distribution of minority ethnic groups across the 20 wards, with almost 15% of the older population in some districts being from minority ethnic groups. Nearly half of people aged 50 or over report themselves as having limiting long-term illness, compared with 36.7% in the whole of England. Some 22.3% of the working-age population is claiming benefits, the 17th highest rate in England, Wales and Scotland. Some 45% of benefit claims in the city are due to reported mental ill health.

The IAPT Pathfinder service is provided by Rethink with the University of York, and there is a range of other services, including some provided by other voluntary sector organisations. The teams use problem-solving approaches and include a skills mix of both low- and high-intensity workers providing a range of short-term, choice-based interventions and support for people with 'common mental health problems', such as depression, anxiety and obsessive compulsive disorders. The teams have skills in providing guided self-help, including information and signposting, well-being support, bibliotherapy, cCBT and bio-psychosocial group-based intervention.

The service also includes community development workers and peer educators working with black and minority ethnic communities. There is an emphasis on well-being, vocational outcomes and collaborative care interventions targeting specific 'disease groups' in primary care, for example people with co-morbid need and frequent consulters. The service also delivers interventions for older people.

5. The service model and care pathways

World Class Commissioning competencies:

- **Promote improvement and innovation** – Making commissioning decisions based on sound knowledge and evidence, ensuring current and future commissioned services address and respond to the needs of the whole population, especially those whose needs are greatest.
- **Prioritise investment** – Setting strategic priorities with partners and making investment decisions focused on the achievement of key clinical, health and community outcomes, including investment plans that address the areas of greatest health inequality.

- 5.1 This section describes some key features of a psychological therapies service, based on available research and best practice examples. The IAPT Implementation Plan⁴⁶ includes more information on characteristics of an IAPT service.
- 5.2 The basic service model envisages a team of therapists taking referrals from GPs, as well as self-referrals, and delivering NICE-compliant therapies at the level required in convenient settings in primary care or elsewhere in the community.
- 5.3 People suffering from depression and/or anxiety disorders often have concerns relating to employment, debt or relationship difficulties. In order to provide an integrated service, which will help people return to normal functioning, therapists are likely to require support from administrative staff, employment advisors (with access to other relevant social supports, such as housing), a GP advisor (to provide medical advice and liaise with other GPs) and other local services with whom they should be fully integrated.

Delivering NICE-compliant treatment

- 5.4 NICE recommends a system of stepped care for delivering psychological therapies⁴⁷ (see Figure 2). The major interventions recommended in NICE guidelines⁴⁸ for common mental disorders are listed overleaf.

⁴⁶ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083150

⁴⁷ www.nice.org.uk/guidance

⁴⁸ Major interventions are defined here as interventions where there is clinical trial evidence in NICE guidelines of greater efficacy over standard care

Low-intensity interventions

- cCBT
- Pure self-help (such as books on prescription where there is no direct support in the use of the materials based on CBT principles)
- Guided self-help (which is facilitated and based on CBT principles)
- Behavioural activation
- Structured exercise
- Psychoeducational groups
- Other therapies

High-intensity interventions

- CBT⁴⁹
- Interpersonal therapy (IPT)
- Counselling
- Couples therapy
- Other therapies

5.5 The majority of people with mild to moderate depression should begin at Step 2 with a relatively brief low-intensity intervention. A person who is more severely depressed will normally require a high-intensity intervention at Step 3. Typically, such an intervention will be provided by a qualified therapist and consist of up to 20 psychological therapy sessions. Others who have not responded to low-intensity treatment will also need Step 3 high-intensity treatment.

5.6 For some anxiety conditions, like post-traumatic stress disorder (PTSD) or social phobia, people normally go straight to high-intensity treatment (usually 7–14 sessions) unless the problem is very mild or recent. High-intensity treatment is also recommended for other persistent anxiety disorders (generalised anxiety disorder (GAD) and panic disorder) that have not responded to low-intensity interventions.

5.7 NICE guidance also recommends considering the concurrent use of medication in moderate to severe (but not mild) depression.

⁴⁹ CBT here is taken to include a wide range of evidence-based interventions including cognitive therapy, problem solving and behavioural activation, all of which are based on CBT principles. CBT has the strongest evidence base for effectiveness across all NICE guidelines.

Figure 2: Stepped-care model of delivery

Staff	Disorder	Intervention
Step 3: High-intensity service	Depression – mild, moderate and severe	CBT, IPT, behavioural activation ³
	Depression – mild to moderate	Counselling, couples therapy
	Panic disorder ¹	CBT
	GAD ¹	CBT
	Social phobia ¹	CBT
	PTSD ¹	CBT, eye movement desensitisation and reprocessing (EMDR)
	Obsessive compulsive disorder (OCD) ¹	CBT
Step 2: Low-intensity service	Depression – mild to moderate	cCBT, guided self-help, behavioural activation, exercise
	Panic disorder – mild to moderate	cCBT, guided self-help, pure self-help ²
	GAD – mild to moderate	cCBT, guided self-help, pure self-help, ² psychoeducational groups
	PTSD	n/a
	Social phobia	n/a
	OCD – mild to moderate	Guided self-help
Step 1: Primary care/IAPT service	Recognition of problem	Assessment/watchful waiting

¹ For these disorders, high-intensity interventions are effective across the full range of severity of the disorder, for example they may be used for some disorders, such as panic disorder, where no benefit from a low-intensity intervention has occurred or where low-intensity interventions are not likely to be effective (PTSD)

² Pure self-help is likely to be of benefit only in milder recent onset cases and in most instances guided self-help is to be preferred

³ For moderate to severe depression, behavioural activation should normally be expected to last for 16–20 sessions

5.8 Stepped care has two principles:

- Treatment should always have the best chance of delivering positive outcomes while burdening the patient as little as possible.
- A system of scheduled review that detects and acts on non-improvement must be in place to enable stepping up to more intensive treatments (or stepping down where a less intensive treatment becomes appropriate and stepping out when an alternative treatment or no treatment becomes appropriate).

5.9 The two principles of stepped care may be implemented in more than one way. In a pure **stepped approach**, almost all patients are offered a low-intensity treatment as the initial step in a treatment programme. Higher-intensity treatments are reserved for those patients who do not benefit from the initial low-intensity step. In contrast, a **stratified approach** assesses patients and allocates them to either low- or high-intensity steps as an initial treatment option.

5.10 There are advantages and disadvantages to both approaches. NICE guidelines take into account the evidence for the effectiveness and likely predictors of response when developing the stepped-care framework for a particular disorder. The degree of emphasis on stepping or allocation will have a major influence on system performance.

5.11 Where commissioners develop service specifications for delivering stepped-care models, they may find system modelling helpful in assessing the capacity that can deliver the required level of access to services. System modelling has been successfully used as part of the national IAPT programme to aid service design and capacity mapping.

5.12 Where deviations from stepped-care principles are agreed, the impact on access and throughput should be explicitly identified in the service specification and contractual framework. Commissioners may wish to balance the potential access benefits of a stepped-care model against the potential risks of an underdeveloped evidence base in making any decision.

5.13 Services may have difficulty meeting demand within reasonable resources unless commissioners make adequate provision for high-prevalence disorders; this is likely to involve significant investment in low-intensity interventions. A ratio of about six to four for high-intensity to low-intensity therapists is likely to be suitable in most services.

5.14 High-intensity treatment is an essential component of an IAPT stepped-care psychological service. A service model that focuses on high-intensity treatments will cost more and treat fewer patients, but sufficient high-intensity resource is needed to prevent waiting lists building up for step 3. Appropriate care pathways integrated with existing psychological therapies and other mental health services, with a smooth transition between steps, will

ensure that the patient experience is not disjointed and the population's range of needs is met. To minimise drop-out after failure to respond to a lower step, it should be made clear to people being treated that a higher step represents a different intervention, not just more of the same.

- 5.15 Whatever the balance between stepping and allocation, the importance of scheduled review cannot be overstated. Unless health and social outcomes are recorded accurately, regularly and frequently for each patient, stepped care cannot be self-correcting. Scheduled review at clinically relevant intervals requires the regular and systematic collection of outcome measures and clinical information (see Section 8).

Choice of services

- 5.16 Patient choice is an important factor in determining outcomes of psychological therapy. There is wide individual variation in the degree to which different therapies are tolerated. Retaining choice within commissioned care pathways therefore remains critical in promoting positive outcomes.
- 5.17 Current NICE guidelines recommend a range of evidence-based treatments for depression and anxiety disorders. Where several treatments are recommended by NICE, commissioners may consider making a range of interventions available to give people a choice of services.
- 5.18 NICE guidelines are based on a body of evidence that will continue to develop over time. Opportunities for collecting outcomes data to show the effectiveness of different approaches should be encouraged. In addition to offering evidence-based psychological treatment, commissioners may wish to specify provision of additional psychological treatments, including innovative ways of offering treatments, providing these are safe and properly evaluated and there are reasonable grounds to assume that they will also be cost effective. Clinicians should explain which treatment they are recommending, and why they think this would be most suitable.

Equality of access

- 5.19 Commissioners may consider a range of access routes to psychological therapy services, although the majority of referrals will be from primary care. Accessing these services in a non-stigmatising way is important, especially as a broad misunderstanding of what constitutes mental health and the stigma associated with negative portrayals of mental illness are still very dominant in society. Professionals, patients and the public need clear and accessible information about how to access local services and the range of choices available. It is also helpful if the referral route passes patients from one professional to another a minimum number of times and minimises bottlenecks in the pathway.

5.20 Commissioners may consider providing services close to people's homes – in GP surgeries, Jobcentres or the premises of voluntary organisations. Support and some low-intensity therapy (guided self-help) can also be delivered over the telephone.

5.21 **Self-referral** has been shown to be a valuable access route for some people. Self-referrers into the Newham IAPT service, for example, were as unwell as those who were referred through primary care services, and had generally been ill for twice as long.⁵⁰ Certain ethnic minority groups were more likely to self-refer than others, illustrating the importance of a variety of access routes to meet the needs of the whole community.

5.22 **Employment support services** can facilitate access for some people. Commissioners may establish referral routes with:

- Jobcentre Plus;⁵¹
- local Pathways to Work/condition management programmes;⁵²
- occupational health services;
- voluntary sector organisations supporting employers and employees; and
- unions and employee representation groups.

5.23 **Probation and offender services** are a potentially important route of referral into psychological therapies services. It is important that people who may not have an address, or may not be registered with a GP, can also benefit from services.

⁵⁰ LSE Economic Evaluation, due spring 2008

⁵¹ www.jobcentreplus.gov.uk

⁵² www.jobcentreplus.gov.uk/jcp/customers/programmesandservices/pathways_to_work/index.html

Employment support in Newham

Mental Health Matters is the lead voluntary sector service provider in the Newham Demonstration Site, providing a fully integrated employment service.

The employment service has been fully operational for over a year and has received 366 referrals (96% from therapists working within Newham IAPT).

Job retention

Twenty-two people were employed when they were referred to the employment support service, of whom 18 are still in work. **The job retention rate is 82%.**

Return to work

Of the remaining 344 referrals, 95 interviews have been attended, 38 clients have found work, 31 people have secured full-time education, 28 people have secured vocational training and 10 people have secured voluntary work. **Of the unemployed referrals, 31% have moved either into work and off benefits or closer to the employment market.**

Job retention/relapse prevention

Clients returning to work are eligible for job retention/relapse prevention. **Of the 38 people returning to work, 32 of them (84%) still engage with the employment team for job retention support.**

6. Workforce planning and development

World Class Commissioning competencies:

- **Promote improvement and innovation** – Specifying required quality and outcomes, and facilitating supplier and contractor innovation that delivers best value, in partnership with local clinicians, practice-based commissioners and providers.
- **Prioritise investment** – Promoting clinical leadership and involvement as a critical and integral part of the commissioning process, ensuring that clinicians advise and lead on issues relating to clinical quality and effectiveness.

- 6.1 Psychological therapies services require competent and qualified therapists to deliver evidence-based treatments within the stepped-care model. Many existing practitioners deliver these therapies. Some of these therapists will need to undertake further training in more specialist psychological therapies (such as high-intensity interventions or CBT) in order to provide the range and depth of therapeutic skills needed. Further guidance on the workforce is available in *A Practical Approach to Workforce Development*.⁵³
- 6.2 Workforce capacity and capability needs to be geared to the likely pattern of demand from people accessing services. The IAPT Workforce Capacity Tool⁵⁴ (see paragraphs 4.3–4.9) has been developed to aid commissioners in estimating the size and skill mix of the workforce required to meet local demand based on each PCT in England.
- 6.3 A ratio of around six to four high-intensity to low-intensity therapists is likely to be required, although this will need to reflect local needs and priorities, and approaches may differ.
- 6.4 Therapists are likely to need support from administrative staff, employment advisors (with access to other relevant social supports, such as housing), a GP advisor (to provide medical advice and liaise with other GPs), and other local services with whom they need to be fully integrated (see paragraph 5.3).

⁵³ [www.newwaysofworking.org.uk/docs/0917_A%20Practical%20Approach%20to%20Workforce%20revised%20\(3\)%20AV_RH%20final.doc](http://www.newwaysofworking.org.uk/docs/0917_A%20Practical%20Approach%20to%20Workforce%20revised%20(3)%20AV_RH%20final.doc)

⁵⁴ www.mhchoice.csip.org.uk/psychological-therapies/workforce/workforce-capacity-tool.html

Psychological therapies competencies

- 6.5 Delivering low- and high-intensity psychological therapies to an appropriate and coherent standard requires competent practitioners who are able to offer effective interventions. Identifying individuals with the right skills is important, but not straightforward. PCTs need to specify the appropriate levels and range of psychological therapies for identified local needs.
- 6.6 The CBT competencies⁵⁵ document is an important aid in this respect. Similar competencies for psychodynamic, humanistic, family and systemic therapies are in development and will be available in late 2008/early 2009.⁵⁶ The competencies for both low- and high-intensity interventions have been used directly to devise standard national curricula⁵⁷ for training therapists through the IAPT programme. Learning and assessment materials for low-intensity training will be available from April 2008.
- 6.7 The British Association of Behavioural and Cognitive Psychotherapy will accredit staff and courses based on revised standards, linked to the CBT competencies.

Importance of supervision

- 6.8 Supervision by appropriately trained and experienced therapists is essential if interventions are to be delivered effectively and achieve outcomes in line with NICE guidelines. Supervision competencies for CBT therapists are being developed together with training materials.⁵⁸
- 6.9 Services will need sufficient numbers of appropriately experienced and trained supervisors, familiar with the range of NICE interventions. Supervisors will also require support, with supervision sessions prioritised in job plans so that high-quality supervision is available to all trainees and qualified staff within the service. Workers delivering low-intensity interventions will also require supervision in high-volume case management.

⁵⁵ www.newwaysofworking.org.uk/pdf/cbtcompetencelist.pdf

⁵⁶ www.newwaysofworking.org.uk/psychology/psychology_documents.aspx

⁵⁷ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083150

⁵⁸ www.newwaysofworking.org.uk/psychology/psychology_documents.aspx

7. Understanding the market

World Class Commissioning competencies:

- **Stimulate the market** – Using investment power to influence improvement, choice and service design, and having in place a range of response providers to choose from.

- 7.1 World Class Commissioning gives PCTs more freedom to commission within a competency framework that requires them to encourage innovation and stimulate local healthcare markets. When commissioning a new service such as psychological therapies, commissioners may want to use this opportunity to invite interest from the broadest possible range of providers to promote the highest quality for the best value, possibly using fixed price contracting.
- 7.2 Nationally, an extensive range of third, independent and statutory sector providers already offers evidence-based psychological therapies. However, in many areas there is limited plurality of provision. Here, PCT commissioners can scope their existing markets so that prospective providers in all sectors are aware of their commissioning intentions in sufficient time to develop the necessary expertise and capacity to tender for this opportunity. Setting up a local provider forum can help engage the provider community constructively and transparently about priorities and issues for market shaping and development.
- 7.3 Commissioners should be able to identify and specify clearly unit costs for interventions at different steps in the care pathway. Costs should be transparent between the independent or third sector and the statutory sector to encourage competition and drive cost-effectiveness. Value-for-money criteria should be included in any tender for new services, as well as criteria to assess the quality of care, so that effective services are commissioned. There should be a clear distinction between grants and legally binding contracts, with appropriate and proportionate reporting mechanisms in place for both.
- 7.4 Other important considerations in commissioning from a wider range of providers are likely to be contract length, enshrining the principles of 'fair and reasonable trading', and the proportionate assignment of risk between commissioner and provider. Education and training resources should be made available across the provider spectrum and not limited to NHS staff.

The role of mental health NHS trusts and NHS foundation trusts

- 7.5 The roles and responsibilities of mental health NHS trusts and foundation trusts in relation to local psychological therapies services need to be considered.
- 7.6 PCTs may decide to commission services from NHS trusts that meet their cost and quality requirements. Indeed, foundation trusts from other parts of the country may wish to tender for services outside their normal boundaries. However, where local mental health trusts do not provide psychological therapies services, the interface between all aspects of the care pathway will need to work well.
- 7.7 Contracts and specifications with mental health trusts and psychological therapies providers should encourage collaborative working, particularly when individuals move between providers along the stepped-care pathway. One area especially likely to require effective collaboration is good-quality supervision, which primary care and new providers might access from secondary care trusts.
- 7.8 Perverse incentives that become a barrier to people receiving the most appropriate level of care need to be avoided. For example, contracts that fund activity alone can lead to delays in people stepping up to another provider. This can be countered by setting clear specifications about when providers should step cases up and by introducing a financial consequence if they do not adhere to the specification.

Involving the third and independent sectors

- 7.9 The third and independent sectors have substantial experience in delivering a range of psychological therapies services. Some organisations will be able to provide psychological therapies across the whole or a substantial part of the potential service. Others will be able to offer a variety of specialist services targeted at specific groups.
- 7.10 A fair approach to risk and information sharing is important so that there are no artificial barriers to third and independent sector participation, e.g. inappropriate financial requirements (such as specifying a certain level of turnover, or not providing full cost recovery), or making untested assumptions about their competencies and delivery capability.
- 7.11 Good information on the range of local, regional and national voluntary sector organisations offering mental health services locally is vital. The Mental Health Providers Forum (MHPF)⁵⁹ provides this at a national level. Many commissioners maintain good relationships and support for a local network; MHPF can advise on developing this where it is not in existence.

⁵⁹ www.mhpf.org.uk

Third sector involvement – Ealing PCT

Ealing commissions a range of mental health services from the third sector, including counselling services, vocational support, meaningful activity day services, art therapy, advocacy and domestic violence support services.

Ealing faces a number of particular challenges in achieving equity of access to services for all sections of the population. Poorer uptake of primary care services from the black and minority ethnic population in some parts of the borough in the past was a key reason why Ealing IAPT Pathfinder commissioning involved the voluntary sector from the beginning, including Anchor Counselling, Asian Family Counselling and the Somali Mental Health Project.

The PCT and local authority have pooled health and social care grant funding to commission voluntary sector services strategically across all care groups. The three-year strategic commissioning cycle provides a more robust and stable platform for providers and helps foster long-term relationships between the sector and commissioners, improving services for vulnerable clients.

Workshops have supported providers in applying for health and social care grants and have shared understanding of what outcomes and monitoring arrangements would be expected from successful providers.

8. Commissioning for outcomes

World Class Commissioning competencies:

- **Secure procurement skills** – Specifying quality standards and outcomes and facilitating good working relationships with providers, offering protection to service users and ensuring value for money.
- **Manage the local health system** – Managing relationships and contracts with providers in order to ensure that the highest possible quality of service and value for money is delivered.
- **Making sound financial investments** – Ensuring that commissioning decisions are sustainable and provide a sound investment to secure improved health outcomes for both now and the future.

- 8.1 Commissioning for outcomes can help ensure cost-effective, high-quality provision. This means clearly specifying the outcomes commissioners expect to see from providers, which can be achieved by collaborating with providers on commissioning expectations in advance of the tender stage, through local provider forums where they exist, and including clear guidance in the service specification document. An example specification document used by one of the Pathfinder sites may be helpful.⁶⁰
- 8.2 Routine collection of outcomes data is fundamental to the effective delivery of psychological interventions. Stepped care cannot be effective in meeting people's changing needs appropriately unless health and social outcomes are recorded accurately, regularly and frequently for each patient. A data collection system can be sourced locally by adapting existing systems or can be bought from a private service provider. Collection of outcomes data is important for people who use services and those who care for them, clinicians, team leaders, local managers, and regional and national policy leads.
- 8.3 Joint commissioning arrangements between PCTs and local authorities, through a joint team or partnership board, can help in:
- planning for current and future mental health needs;

⁶⁰ www.mhchoice.csip.org.uk

- commissioning through service specifications and service level agreements;
- monitoring and performance managing service suppliers, for example in the areas of expenditure, demand, budgetary pressures, volume and quality of services;
- developing and improving services; and
- overcoming barriers caused by different financial regimes and information and separate systems for data collection.

8.4 Commissioners may want psychological therapies services to demonstrate that they are delivering:

- the **right services** – the stepped-care system applied to an integrated care pathway, with a NICE-compliant range of evidence-based interventions across all stepped care;
- the **right numbers** – of referrals and people treated relative to the PCT's population. Service uptake monitoring shows whether local people have equitable access, particularly where sections of the community have previously found services unacceptable or not culturally relevant;
- at the **right time** – shorter waiting times between referral, assessment and the start of treatment; and
- the **right results** – health and well-being gains, changes in employment status, social inclusion and indicators of patient satisfaction (which can be useful in assessing how acceptable services are to local people).

8.5 Guidance on appropriate measures to demonstrate these outcomes can be found in the IAPT outcome framework for 2007/08,⁶¹ which is being updated. New guidance, including good practice examples from IAPT pilot sites and covering a range of data collection models and their workforce, IT equipment and outcome measurement training implications, will be available in spring 2008.

8.6 The key principle of outcomes management is placing the needs of people who use services at the centre of any desired outcome. There is no single method of involving service users, either to help define outcomes or to inform practitioners and managers about the success of a period of psychological intervention. Practitioners may need training to carry out effective user evaluation. For example, mailing questionnaires to individuals who have used a service does not usually produce good qualitative data about service use. The principles and benefits of outcomes management are set out in Table 1.

⁶¹ www.mhchoice.csip.org.uk/silo/files/iapt-outcome-framework-and-data-collection.pdf

Table 1: Principles and benefits of outcomes management

Principles	Benefits
The primary purpose of outcomes measurement is to improve people’s experience of and benefits from the service and is part of ongoing, collaborative service evaluation, with feedback from patients at its heart	People chart their progress towards recovery and see at what point their psychometric score falls within the normal range. If the goal is to reduce or stop medication, this can help decide the right time
Sessional outcomes feedback to clinicians helps improve the quality of their interventions	People set their own goals for therapy, and give ongoing feedback on whether therapy is working and which elements are helpful or unhelpful
Regular outcomes feedback to supervisors supports case reviews and collaborative treatment planning	If people wish, they can ask their carers (loved ones, family or friends) to help with setting goals, step-by-step changes, and giving additional feedback on progress
Routinely collected outcomes data helps managers monitor and improve overall service performance	Therapists and supervisors, and the clinical team, can also chart progress, and can adjust treatment plans if the feedback indicates that the current plan is not working. Likewise, clinicians can check performance against their peers, to keep their skills in good shape
Service performance data informs PCT/SHA managers who set national standards to aim for	GPs and clinicians doing initial assessments for therapy can engage patients and work collaboratively. For example, if getting back to work is what the patient wishes, they will be encouraged to take responsibility for this as part of their therapeutic outcome
Intelligent use of aggregate outcomes data by experts aims to define best practice models of service delivery	Service managers can use the outcomes framework to manage performance and improve quality, which also helps commissioners ensure that contracts and the funding of services are providing good value for money

Table 1: Principles and benefits of outcomes management *(continued)*

Principles	Benefits
<p>Ask fewer questions, get more answers. The requirement for data collection should be proportionate to the treatment being offered and integrated with clinical priorities. The utility of data is enhanced if a complete set of minimum data is obtained for each intervention</p>	<p>Local, regional and national leads will benefit from having accurate, comprehensive outcomes data being fed in to the policy-making system, which can help drive up standards by setting benchmarks and establishing league tables. Whole-system care pathways can be improved by using high-quality practice-based data. Future resource planning will also be improved</p>

Annex – Resources

- Carers UK
www.carersuk.org
- *The competencies required to deliver effective cognitive and behavioural therapy for people with depression and anxiety disorders*
www.newwaysofworking.org.uk/pdf/cbtcompetencelist.pdf
- *Commissioning framework for health and well-being*
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604
- *The Commissioning Friend for Mental Health Services*
www.natpact.nhs.uk/uploads/2005_Jan/MH_Screen_Version.pdf
- *No excuses. Embrace partnership now. Step towards change! Report of the Third Sector Commissioning Taskforce*
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137144
- CSIP directory of service improvement methodologies
www.csip.org.uk/resources/directory-of-service-improvement/methodologies.html
- Health inequalities intervention tool
www.lho.org.uk/HEALTH_INEQUALITIES/Health_Inequalities_Tool.aspx
- *Improving Access to Psychological Therapies implementation plan: National guidelines for regional delivery*
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083150
- IAPT outcome framework 2006/07
www.mhchoice.csip.org.uk/silo/files/iapt-outcome-framework-and-data-collection.pdf
- IAPT website
www.mhchoice.csip.org.uk
- IAPT Workforce Capacity Tool
www.mhchoice.csip.org.uk/psychological-therapies/workforce/workforce-capacity-tool.html

- Government News Network (press releases)
www.gnn.gov.uk
- Jobcentre Plus
www.jobcentreplus.gov.uk
- JSNA guidance
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097
- Mental Health Foundation
www.mhf.org.uk
- Mental Health Providers Forum
www.mhpf.org.uk
- National Stroke Strategy
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081062
- National Survivor User Network
www.nsun.org.uk
- New Ways of Working website
www.newwaysofworking.org.uk
- *Good practice guide on the contribution of applied psychologists to Improving Access for Psychological Therapies*
[www.newwaysofworking.org.uk/pdf/Improving%20Access%20\(IAPT\).pdf](http://www.newwaysofworking.org.uk/pdf/Improving%20Access%20(IAPT).pdf)
- NHS Choices guide to talking therapies
www.nhs.uk/livewell/mentalhealth/Pages/Talkingtherapies.aspx
- NICE commissioning guide on CBT for common mental health problems
www.nice.org.uk/usingguidance/commissioningguides/commissioning_guides_8211_supporting_clinical_service_redesign.jsp
- NICE clinical guideline on anxiety (panic disorder and generalised anxiety disorder)
www.nice.org.uk/guidance/index.jsp?action=byID&o=10960
- NICE clinical guideline on depression
www.nice.org.uk/guidance/index.jsp?action=byID&o=10958

- NICE clinical guideline on obsessive-compulsive disorder
www.nice.org.uk/guidance/index.jsp?action=byID&o=10976
- NICE clinical guideline on post-traumatic stress disorder
www.nice.org.uk/guidance/index.jsp?action=byID&o=10966
- Pathways to Work/Condition Management Programme
www.jobcentreplus.gov.uk/jcp/customers/programmesandservices/pathways_to_work/index.html
- Patients at risk of re-hospitalisation (PARR) case finding tool
www.kingsfund.org.uk/health_topics/patients_at_risk/index.html
- Patient information toolkit
www.nhsidentity.nhs.uk/patientinformationtoolkit/patientinfotoolkit.pdf
- *A Practical Approach to Workforce Development*
[www.newwaysofworking.org.uk/docs/0917_A%20Practical%20Approach%20to%20Workforce%20revised%20\(3\)%20AV_RH%20final.doc](http://www.newwaysofworking.org.uk/docs/0917_A%20Practical%20Approach%20to%20Workforce%20revised%20(3)%20AV_RH%20final.doc)
- Together (national charity working for well-being)
www.together-uk.org
- Strategic Health Asset Planning and Evaluation (SHAPE)
www.dh.gov.uk/ProcurementAndProposals/PublicPrivatePartnership/PrivateFinanceInitiative/InvestmentGuidanceRouteMap/InvestmentGuidanceArticle/fs/en?CONTENT_ID=4133060&chk=1FULSf
- World Class Commissioning
www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/index.htm



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