NHS

The Improving Access to Psychological Therapies Manual

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

The Improving Access to Psychological Therapies Manual

Gateway reference: 08101

Version number: 5

Updated: August 2021

First published: June 2018

Prepared by: The National Collaborating Centre for Mental Health

Classification: OFFICIAL

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request.
Please contact 0300 311 22 33 or email england.contactus@nhs.net stating that this document is owned by Mental Health Policy Team, Operations and Information Directorate.

Disclaimer
Healthcare professionals are expected to take NICE clinical guidelines fully into account when exercising their clinical judgement. However, the guidance does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of each patient, in consultation with the patient and/or their guardian or carer.

Copyright
National Collaborating Centre for Mental Health, 2021.

Contents

Foreword 4
1 Introduction 5
2 Conditions treated by IAPT services 10
3 The importance of delivering evidence-based care 13
4 The workforce 16
5 Delivering effective assessment and treatment 24
6 The importance of data: monitoring clinical outcomes and activity 31
7 Getting better results: improving access 42
8 Getting better results: reducing waiting times 44
9 Getting better results: improving recovery 50
10 Getting better results: improving equity of access and outcomes for all 58
11 Working with the wider system: improving care 63
12 Key features of a well-commissioned IAPT service 68
Annex: Position statement on staffing standards in IAPT services 74
Definitions of terms and abbreviations 82
References 85

Appendices

Appendix A: NICE-recommended care 89
Appendix B: Competence frameworks 90
Appendix C: IAPT screening prompts 95
Appendix D: Clinical cut-offs and reliable change 97
Appendix E: Examples of patient tracking lists (PTLs) 98
Appendix F: Development team 100
Appendix G: Bite-sized Positive Practice Guides 101
Appendix H: Helpful resources 116

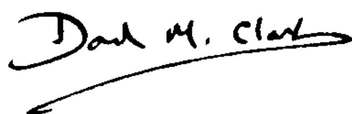
Foreword

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 psychological therapies as first choice interventions for depression and anxiety disorders. However, in most countries few members of the public benefit from these advances because 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 1.15 million people a year. Over 600,000 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 1.9 million people per year will be seen by 2023/24. 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. From small beginnings in 2008, IAPT has steadily grown so that over 1.15 million people were able to access the services in 2019/20. This expansion was largely the result of training and deploying over 8,000 new psychological therapists and practitioners. Taken together The Five Year Forward View for Mental Health[1] and The NHS Long Term Plan commit the NHS to further expand the IAPT programme so that 1.9 million people per annum will be able to access the services by the end of 2023/4.

IAPT recognises two types of valid clinical activity. The first is assessment, normalisation, simple advice and, if appropriate, signposting elsewhere. This is usually a single session activity. The second is providing a multi-session course of NICE-recommended psychological therapy for anxiety-related problems and/or depression to people for whom that is indicated. Nine out of ten people are seen within 6 weeks of referral. The outcomes achieved with people who have a course of treatment are broadly in line with the expectation from clinical trials. Approximately one in two people recover and two out of three people show worthwhile improvements in their mental health.

1.1 Purpose and scope

The IAPT 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.[b]

This manual encompasses the following priorities for service development and delivery:

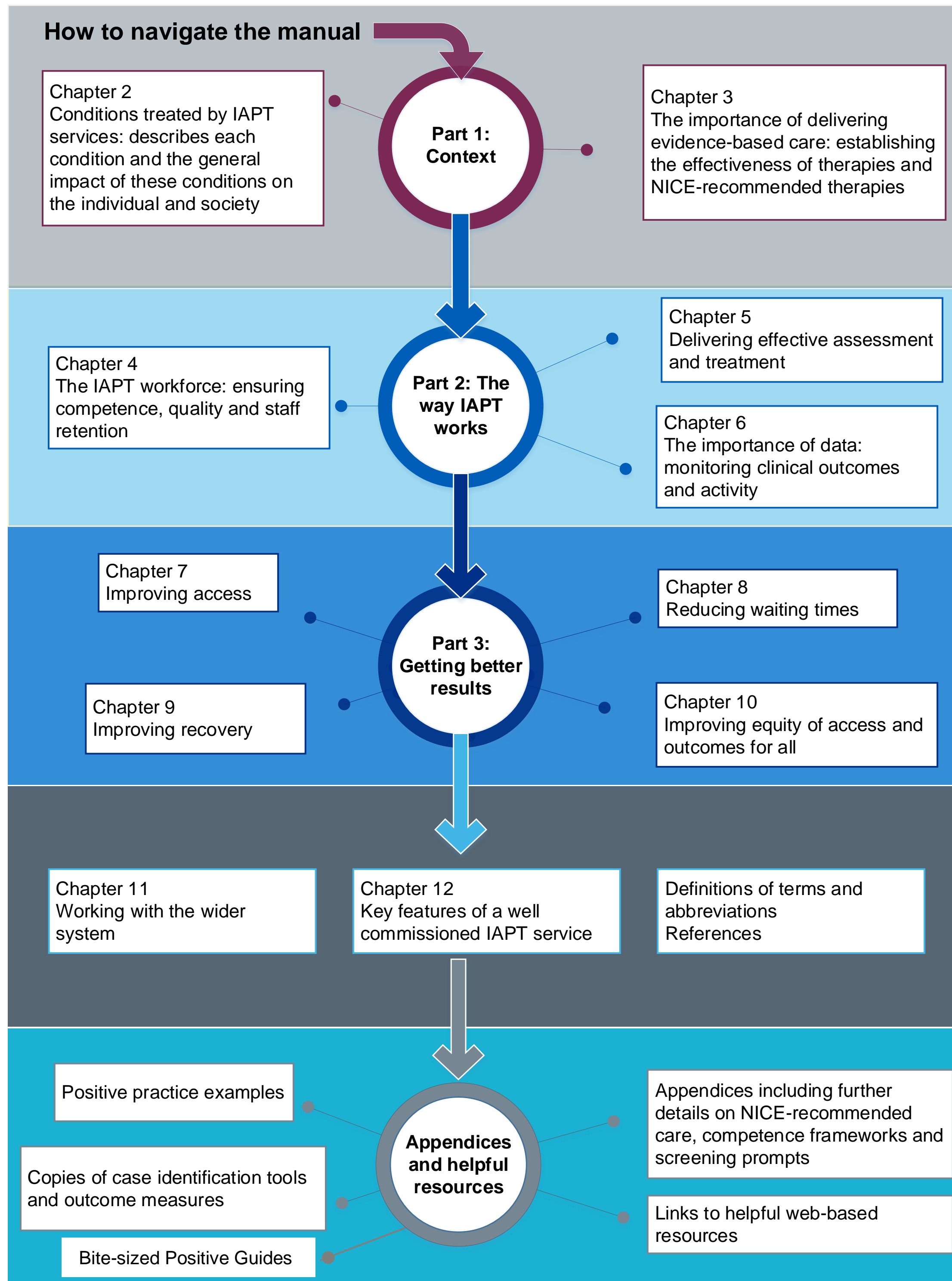
- Expanding services so that at least 1.9 million adults can access care each year by 2023/24.
- Focusing on people with depression and/or any of the anxiety disorders. As IAPT services expand they are expected to increase access to treatment for people who also have long-term physical health conditions, 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 IAPT services can better meet individual employment needs and contribute to improved employment outcomes.
- Provision of digitally enabled models of therapy for depression and anxiety disorders.

[a] Information on children and young people's IAPT services can be found here.
[b] The list of developers can be found in Appendix F.

1.2 Navigating the manual

The manual has been organised into 11 further chapters as set out in Figure 1, which provides a brief overview of each chapter's content.

Figure 1



1.3 What are IAPT services?

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[c]). IAPT services are characterised by three key principles:

1. **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.
2. **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 continually improve.
3. **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 are IAPT services 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):

- agoraphobia
- body dysmorphic disorder
- depression
- generalised anxiety disorder
- health anxiety (hypochondriasis)
- mixed depression and anxiety (the term for sub-syndromal depression and anxiety, rather than both depression and anxiety)
- obsessive-compulsive disorder (OCD)
- panic disorder
- PTSD

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

- social anxiety disorder
- specific phobias (such as heights or small animals).

It is recognised that many people experience 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 has been extended to people with comorbid LTCs or MUS (see Section 11.2). The newly developed IAPT-LTC services focus on people who have LTCs in the context of depression and anxiety disorders. They also aim to treat the following conditions:

- chronic fatigue syndrome
- irritable bowel syndrome (IBS)
- 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 Bite-sized 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.

Mental health transformation sees the development of new ways of bringing together primary and secondary care with local communities, to support people with mental health conditions. As a key part of the system, IAPT plays a vital role in this transformation and is integral to true integration across mental and physical health, social care, the voluntary sector and wider services. Throughout this transformation it is important that IAPT services remain in line with their evidence base and only provide support to those that will benefit from the uni-professional interventions offered.

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 one and three traumas that result in intrusive memories could be treated in IAPT services.

Historic or current suicidal ideation and past suicide attempts should not automatically exclude someone from accessing the support of an IAPT service. It is important to remember that thoughts of suicide are often part of an individual's experience of anxiety and

depression. However, if someone currently has clear plans or intent to act on these thoughts, IAPT services are not best placed to meet the patient's needs. In these situations, support from more appropriate specialist services should be drawn upon.

Historic or current self-harm, without suicidal intent, should also not automatically exclude someone from accessing the support of an IAPT service where clinical assessment indicates that the client's presenting problem is one suitably treated by IAPT (depression and anxiety-related disorders). Self-harm can be common in conditions (including psychosis, personality disorders and eating disorders) that are not appropriately treated by IAPT and careful assessment is required to determine which service/s are most appropriate to meet the patient's current need.

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:

1. self-referral
2. community or voluntary service referral
3. primary care referral
4. 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
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.
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.
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.
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.
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.
Irritable bowel syndrome (IBS)*	A common functional gastrointestinal disorder. It is a chronic, relapsing and often lifelong disorder, characterised by the

Condition	Description
	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.
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).
MUS not otherwise specified*	Distressing physical symptoms that do not have an obvious underlying diagnosis and/or pathological process.
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.
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.
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.
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.
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.

* 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 (Gross National Product) 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) with 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 2019/20 IAPT annual report, the initial average severity of IAPT

depression scores was on the borderline between mild-moderate and moderate-severe[d] 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[e] 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	

[d] Patient Health Questionnaire – 9 items (PHQ-9) score was 17.2.

[e] 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.

	Condition	Psychological therapies	Source
	Depression Prevention of relapse	CBT or mindfulness-based cognitive therapy[f]	
	Generalised anxiety disorder	CBT, Applied relaxation	NICE guidelines: CG113, CG123
	Panic disorder	CBT	NICE guidelines: CG113, CG123
	PTSD	Trauma-focused CBT, Eye Movement Desensitisation and Reprocessing[g]	NICE guidelines: NG116
	Social anxiety disorder	CBT specific for social anxiety disorder[h]	NICE guideline: CG159
	OCD	CBT (including exposure and response prevention)	NICE guidelines: CG31, CG123
	Chronic fatigue syndrome	Graded exercise therapy, CBT[i]	NICE guideline: CG53
	Chronic pain	Combined physical and psychological interventions, including CBT and exercise	NICE guideline: NG59 Informal consensus of the EAG[j]
	IBS	CBT	NICE guideline: CG61 Informal consensus of the EAG
	MUS not otherwise specified	CBT[i]	Informal consensus of the EAG
Note: NICE depression guidance currently being updated. Expected publication: May 2022. NICE chronic fatigue syndrome currently being update. Expected publication: August 2021.			

See Appendix A for a list of NICE guidance relevant to the conditions treated within IAPT services.

[f] 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.

[g] If no improvement, an alternative form of trauma-focused psychological treatment or augmentation of trauma-focused psychological treatment with a course of pharmacological treatment.

[h] Based on the Clark and Wells model or the Heimberg model.

i Specialised forms of CBT.

[j] The NHS England IAPT Expert Advisory Group (EAG) 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).[k] All clinicians should be accredited by relevant professional bodies and 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.

4.1.1 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, with linked professional registration with the relevant professional body following training. 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.

4.1.2 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. NICE recommends five different high-intensity therapies for depression (CBT, IPT, brief psychodynamic therapy, counselling for depression and couple therapy).

In addition to offering CBT, commissioners and providers should ensure patients with depression (who comprise about 40% of referrals) are provided with a meaningful choice of high-intensity therapies. To make this possible, it is recommended that between 10% and 30% of a service's total high-intensity workforce (whole-time equivalents [WTEs]) comprises

[k] 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.

individuals who have been trained to deliver depression treatments other than CBT. Staff proportions towards the higher end of this range would be appropriate if the service aims to have substantial capacity in multiple non-CBT therapies. The lower end of the range is more appropriate if only one non-CBT therapy is offered. All services are expected to have capacity to offer couple therapy to individuals who are depressed in the context of a relationship issue and have a partner who is willing to work with the patient in therapy.

Table 3: High-intensity therapies training and course accreditation[i]

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	National Curriculum for High Intensity Cognitive Behavioural Therapy Courses	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	Curriculum for Mindfulness-based Cognitive Therapy	

[i] Latest curricula information can be found at: www.hee.nhs.uk/our-work/mental-health/improving-access-psychological-therapies

High-intensity therapy type	Explanation of NICE-recommended therapy type	IAPT curricula	Course accredited by
	often delivered in groups and starts after an initial intervention for an acute episode has been completed		
LTCs/MUS	CPD 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	

4.1.3 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.

4.1.4 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 people 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 into the service, as well as efficient mechanisms to support the flow through the system.

Assistant psychologists are employed by some services to assist in the design and implementation of audit and research projects. These roles can be helpful in driving forward service quality improvement initiatives. However, they are not clinical delivery roles in IAPT. In some situations, assistant psychologists may join a qualified clinician in a session, to assist (particularly with groups). However, they should not run sessions on their own and must not deliver triage, clinical assessments or interventions independently without a qualified IAPT clinician present and leading.

4.1.5 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 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 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 4.1.6). 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.

4.1.6 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 competence 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.
- There is an expectation that this supervision is model-appropriate to support the fidelity of each evidence-based approved modality.
- Supervision should take place weekly, consisting of at least 1 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.
- Regular live or recorded observation within supervision to allow detailed feedback on practice issues and fidelity to the model, including the use of fidelity/competence rating scales for the modality.
- PWPs should receive both case management supervision (individual, 1 hour per week) and clinical skills supervision (at least 1 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 2-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).

4.1.7 Pay

IAPT services should not contract with any individuals with IAPT-recognised qualifications and accreditations, or those undertaking IAPT modality trainings, to operate in any unpaid capacity. Services should offer substantive employment and avoid contracts with practitioners that only remunerate them for sessions attended.

IAPT services may host a variety of trainees. These include trainees paid directly by the IAPT service and trainees who may be paid by another part of the NHS (for example, a clinical psychology training programme). Other trainees sometimes undertake contracted training placements in a voluntary capacity. The clinical activity of unpaid trainees should not be included in the IAPT service's key performance indicators.

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 developed 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 information technology (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 continuing professional development:

- 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 champions, for example specific protected characteristics, digital, staff wellbeing, and so on
- 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
- develop staff wellbeing forums.

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 patients 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/home working environments 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

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, many 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 organise continuing professional development initiatives and maintain national standards if individuals only stay in role for a very short period after training. It is strongly recommended that PWPs stay in role for at least 3 years after completing their training. PWPs will not be funded for high-intensity training unless they have worked as a PWP for at least 2 years after completing their PWP training.[m] Services should aim to recruit staff from a

[m] This rule should be applied in such a way that it confers no disadvantage as a result of any protected characteristic. As such, periods of maternity leave should be counted towards the two years, and evidenced gaps in employment because of disability, illness or caring responsibilities should also be considered part of the 2 years.

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. Supporting part-time training and working for both PWPs and high-intensity therapists is likely to help create a more diverse and stable workforce.

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, people from ethnic minority groups, younger adults,[n] 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 human resources 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. The revised IAPT Dataset (v2.0) requires services to record for every member of the clinical workforce their qualifications for delivering particular IAPT-compliant treatments.

[n] 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):**
  - 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) (International Statistical Classification of Diseases and Related Health Problems 10th edition [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 Data Set,** including any appropriate anxiety disorder specific measures (ADSMs) and/or the LTC/MUS outcome measures as indicated by the problem descriptor.

5.1.3 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

5.1.4 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 Data Set 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)

	CMD in past week, as identified by CIS-R			
	Depression	Phobias	OCD	Panic disorder
Ever diagnosed with CMD by professional (self-reported)	%	%	%	%
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[o] 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).

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.

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

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

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'.

5.1.5 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 ADSM or 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.

5.1.6 Clustering

The use of clustering within IAPT is currently under review. If services find the use of this tool helpful, clustering on treatment entry is recommended and can benefit decision-making within local pathways to ensure patients receive the right level of care. It is important to note that this tool is one index of a person's care needs and all aspects of an individual should be considered when determining the appropriate level of care required. Models to support pricing and payment in a clinically appropriate way will be shared as available.

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.

5.2.2 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.

5.2.3 Post-traumatic stress disorder (PTSD) and social anxiety disorder

In contrast to most other conditions treated in IAPT services, NICE[14 15] does **not** recommend stepped care for PTSD or social anxiety disorder. Instead, individuals with either of these conditions should be immediately offered a course of the relevant, specialised high-intensity therapy. For PTSD, the recommendation is for either trauma-focused CBT or eye movement desensitisation and reprocessing (EMDR). For social anxiety disorder, the recommendation is a course of individual CBT based on either the Clark and Wells or Heimberg model. Services should ensure that they have sufficient high-intensity therapists trained in these treatments to offer them promptly. Because the treatments are specialised, it is important that the therapists benefit from supervision by senior clinicians who are themselves trained in the treatments. Services may wish to consider creating specialist PTSD and social anxiety disorder care pathways so that most cases are treated by clinicians who have a particular interest in these conditions. This can be an efficient and effective way of deploying clinical resources.

Services should monitor waiting times for NICE-recommended treatment of PTSD and social anxiety disorder and take appropriate action if these are excessive. Longer waiting times may be due to a shortage of appropriate staff. A less than complete initial assessment can also lead to excessive waits. PTSD is just one of the many mental health conditions that can be triggered by a traumatic event. It is therefore important that services do not put an individual on a waiting list for PTSD treatment just because a trauma is reported at assessment. In such instances, it is wise to screen for PTSD using the full PCL-5 or a validated short version.[16]

If the individual screens positive, follow-up questions should be used to confirm PTSD and that it is the main problem requiring treatment. Similarly, if social anxiety disorder is suspected, screening with the Social Phobia Inventory (SPIN) or the 3-item Mini-SPIN[17] (scores ≥6 indicate probable social anxiety disorder) followed by appropriate follow-up questions is recommended. Assessors should be aware that the extensive avoidance of feared situations that can occur in social anxiety disorder means that a sizeable proportion of patients who score above threshold on the SPIN and are disabled by the condition will score below threshold on the GAD-7 at assessment. This should not be a reason for withholding the appropriate high-intensity therapy.

The NICE-recommended forms of CBT for PTSD and social anxiety disorder both require therapists to conduct some client sessions out of the office (revisiting the site of the trauma, some behavioural experiments). Services should make provision for this work and also

ensure that longer sessions (up to 90 minutes) are scheduled when required (for example, for behavioural experiments or trauma memory work). On average treatment of PTSD is likely to require more sessions for clients who have experienced multiple traumas than those with a single trauma. Video feedback is a central procedure in the treatment of social anxiety disorder. Services should make suitable equipment available. High-intensity therapists who wish to further develop their skills can find illustrative videos on PTSD assessment, and key manoeuvres for treating PTSD and social anxiety disorder at oxcadatresources.com.

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.[18]

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 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 policymaking.

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 Data Set 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 clinical time is not used for the completion of measures. Questionnaires are often completed in hard copy or through an online portal at home, or while a person is in the waiting room. 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 remotely over the telephone or video 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 remote session with their clinician. This practice is strongly recommended. Some IT providers have recently made it possible for patients to enter their data using a link in an SMS (short message service) text from the service.

When services encourage patients to enter their questionnaires remotely in advance of a session, it is important to have a governance system in place to identify and act on any deterioration or risk indicated in returned outcome measures, even if the patient fails to attend the scheduled appointment.

All IAPT services are expected to have local IT systems that support the collection and reporting of the data set. 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 Data Set 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**. The PEQ should also be administered at the end of assessment and at the end of treatment 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 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*	Measure of disability
Agoraphobia	**PHQ-9**	**MI**	GAD-7	WSAS
Body dysmorphic disorder (BDD)	**PHQ-9**	**BIQ**	GAD-7	WSAS
Chronic fatigue syndrome	**PHQ-9**	**CFQ**	GAD-7	WSAS
Chronic pain (in context of anxiety/depression)	**PHQ-9**	**GAD-7**		WSAS
Depression	**PHQ-9**	**GAD-7**		WSAS
Generalised anxiety disorder	**PHQ-9**	**GAD-7**		WSAS
Health anxiety (hypochondriasis)	**PHQ-9**	**HAI**	GAD-7	WSAS
Irritable bowel syndrome (IBS)	**PHQ-9**	**IBS-SSS**	GAD-7	WSAS
Mixed anxiety/depression	**PHQ-9**	**GAD-7**		WSAS
MUS not otherwise specified	**PHQ-9**	**PHQ-15**	GAD-7	WSAS
No problem descriptor	**PHQ-9**	**GAD-7**		WSAS
OCD	**PHQ-9**	**OCI**	GAD-7	WSAS
Panic disorder	**PHQ-9**	**PDSS**	GAD-7	WSAS
PTSD	**PHQ-9**	**PCL-5**	GAD-7	WSAS
Social anxiety	**PHQ-9**	**SPIN**	GAD-7	WSAS

* Further option is only used if 'recommended measure for anxiety symptoms or MUS' is missing.

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: Agoraphobia-Mobility Inventory (MI) – above an item average of 2.3; Body Image Questionnaire (BIQ)* – 40 and above; Chalder Fatigue Questionnaire (CFQ) – 19 and above; Francis Irritable Bowel Syndrome Symptom Severity Scale (IBS-SSS)* – 75 and above; Generalised Anxiety Disorder Assessment (GAD-7) – 8 and above; Health Anxiety Inventory (HAI) – 18 and above; Obsessive-Compulsive Inventory (OCI) – 40 and above; Panic Disorder Severity Scale (PDSS) – 8 and above; Patient Health Questionnaire-15 (PHQ-15)* – 10 and above; Patient Health Questionnaire-9 (PHQ-9) – caseness is 10 and above; PTSD Checklist for DSM-5 – Posttraumatic Checklist (PCL-5) – 32 and above; Social Phobia Inventory (SPIN) – 19 and above.

** BIQ, IBS-SSS, CFQ and PHQ-15 have now had their reliable change values calculated. Further comms will be issued to confirm when these measures will be used for paired scores and recovery calculations within NHS Digital publications.*

Further information on these measures can be found in Appendix H.

6.2.1 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:

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

Given these omissions, IAPT guidance now recommends that clinicians also administer a well validated measure that is specific to the symptoms of these disorders, if they are the main focus of treatment. This ensures that clinicians can 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 a result of more avoidance. In the latter case, the clinician would need to focus the next few sessions on overcoming avoidance.

Similarly, the SPIN can detect disabling social anxiety in individuals who score near or below the clinical cut-offs on the GAD and PHQ. Regular use of the SPIN with such individuals will help ensure they get the right treatment and that it continues long-enough to promote full recovery, even if GAD/PHQ scores are already below threshold.

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 CFQ. 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 and The NHS Long Term Plan, 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 a MUS measure (Francis IBS Scale, CFQ or PHQ-15[p]), as appropriate.

- **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. Helpful measures for particular LTCs are:
    - Diabetes Distress Screening Scale
    - COPD Assessment Test (CAT)
    - 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.

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

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.[18] 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 Data Set 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 seen in IAPT services
- waiting time standard
- recovery rate standard: for people who have a course of treatment.

6.4.1 Access standard

The access standard for IAPT services to achieve by 2020/21 was 1.5 million people, which was 25% of the community prevalence of depression and anxiety disorders (using estimates from the APMS 2000). The NHS Long Term Plan commits the NHS to further expand the IAPT programme so that 1.9 million people will be seen in services by 2023/24, ensuring an additional 380,000 adults and older adults will be able to access NICE-approved IAPT services.

Definition of 'access'

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), in which case 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 data set 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 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.

Access[a] is a count of everyone who attends at least one clinical appointment, had an assessment, was given advice and psychoeducation, and was either signposted elsewhere or offered a multi-session course of IAPT treatment. A patient is coded as having 'accessed IAPT' if at least one session is recorded as either 'assessment and treatment' or 'treatment'.

It is important that the 'assessment and treatment' and 'treatment' codes are only used when a significant portion of a session is devoted to delivering an appropriate psychological intervention that is supported in IAPT.[19]

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, sessions that exclusively focus on assessment or 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[19] 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.

Courses of treatment

A person is deemed to have had a course of treatment in IAPT if the individual has had at least two sessions (coded as 'assessment and treatment' and/or 'treatment') before discharge. Of course, most people have many more sessions. Services aim to record and report the outcomes of all individuals who have had even this minimal dose of therapy, irrespective of their reasons for discharge. In NHS Digital reports, 'courses of treatment'[q] is the count of everyone who had at least two treatment sessions in IAPT and was discharged in the reporting time period.

[q] 'Courses of treatment' is sometimes termed 'finishing treatment' within reports.

Access measures all people who receive IAPT-recognised advice and signposting or start a course of IAPT treatment. It is important that the number of people receiving a course of treatment is also closely monitored (using 'courses of treatment'/'finished treatment' metric) to ensure appropriate balance between the different clinical functions of IAPT. The ambition is for the number of people having a multi-session course of treatment to be 60% of all those accessing IAPT.

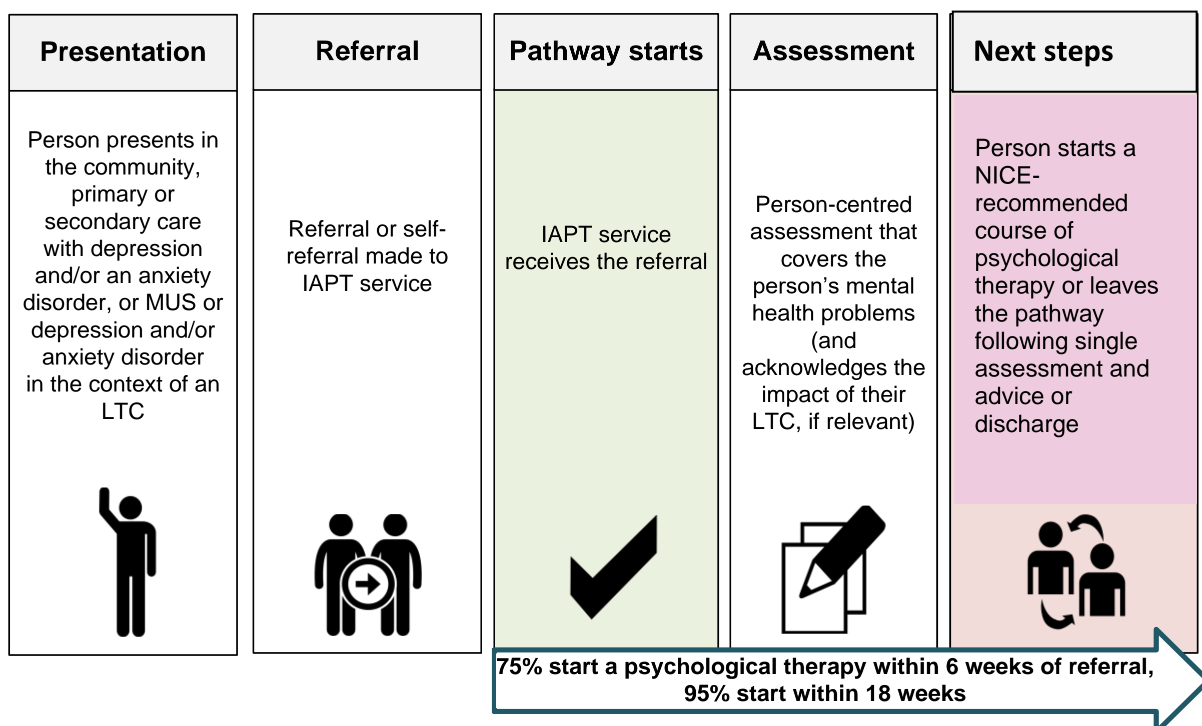
6.4.2 Waiting times standard

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



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. Waits for high-intensity therapy (either as a first intervention or after step-up) should not be substantially longer than waits for low-intensity therapy.

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.

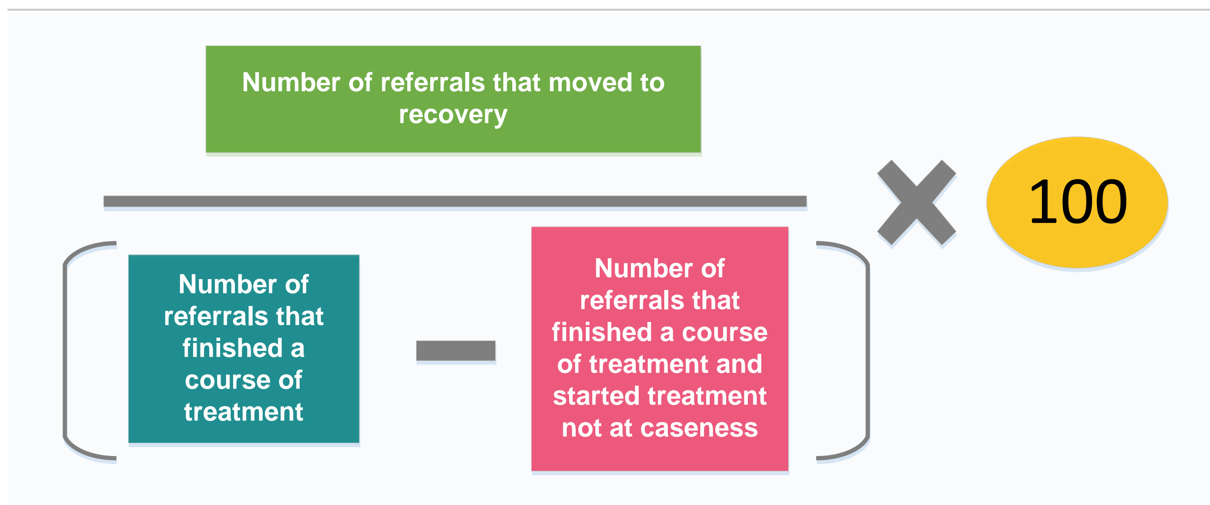
6.4.3 Recovery standard

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 data set 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



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.

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/MUS 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 re-join 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 who receive IAPT-recognised assessment, advice and signposting or start a course of IAPT 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 2023/24 it is expected that 1.9 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 by the end of 2019/20 it was seeing 1,165,653 patients per year. This expansion is largely the result of training and deploying over 8,000 new psychological therapists and practitioners. The NHS Long Term Plan commits the NHS to further expand the IAPT programme so that 1.9 million people will be seen in the services by 2024. This will only be possible if commissioners plan for a substantial expansion of the workforce, in line with indicative workforce modelling in the NHS Mental Health Implementation Plan. It is estimated that the average CCG will need to expand the number of clinicians employed in its IAPT service by between 60% and 75%. 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 2024 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[18] and through analyses of the first year of the programme.[20] 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.[21] This could include the Whooley Questions, Generalised Anxiety Disorder scale – 2 items (GAD-2) or Mini-Social Phobia Inventory Scale (see Appendix H).
- 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 5.1.4). 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 (IAPT-LTC services) in addition to delivering services from multiple community locations
- use of technology, such as:
  - engaging with the community and voluntary sector social media networks to reach high volumes of people
  - appealing to different communication and learning preferences by using video clips and animations
  - 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 IAPT 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 assessment and 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 a single day if necessary, rather than just relying on voice messages).
- 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

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 (for example, longer appointments for home visits)
- availability of fit-for-purpose technology (for example, 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 administrative 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:

    - be based on realistic expectations of productivity and consider expected loss of capacity due to annual leave, sickness and staff training events
    - consider missed appointments and short-notice cancellations, because rescheduling after a missed appointment requires an extra session of therapist time
    - 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:

    - 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.
    - 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.
    - 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.
    - 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 because 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 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 because 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.
  - 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**
  - 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'**
  - It is good practice to review PTLs on a regular (weekly or fortnightly) basis and agree team action.
- **Senior oversight and governance**
  - 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.
  - A clear escalation policy should be in place to support booking staff where they are unable to offer appointments in line with the agreed (national and service specific) wait standards.

Additional guidance

The waiting time standards calculations can be found in the IAPT Waiting Times Guidance and FAQ's.

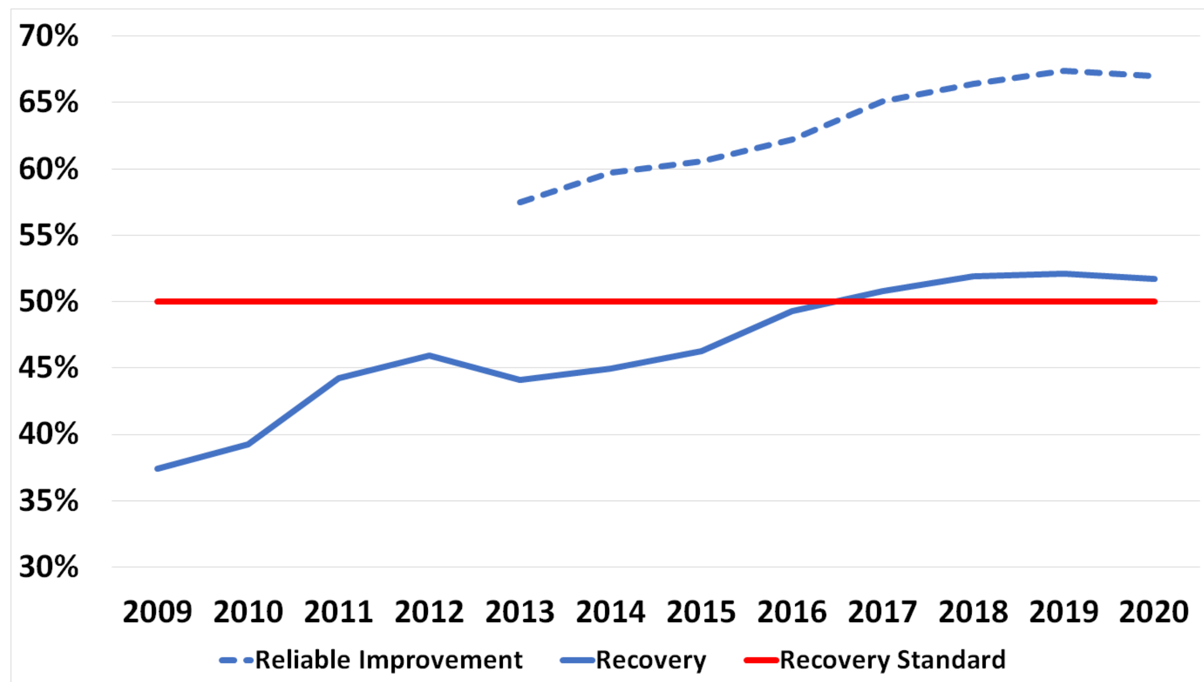
Detailed guidance and frequently asked questions (FAQs) on first treatment definitions and associated terminology can be found in the Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16.

9 Getting better results: improving recovery

At least 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 over 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.[20] 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.[20 22]

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 nine to ten 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 six) 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, including the following factors:

- 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[23] 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 to move from an average recovery percentage in the mid-40s to a better one in the mid-60s.[24] 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.[25] 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.[18] However, a recent follow-up of PWP treatment in one IAPT service was less positive.[26] 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 shows a comparison between the characteristics of better and worse performing IAPT services.

Table 7: Summary of contrast between shared characteristics of better 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. Depression or anxiety disorders can affect anyone, so 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 for how they will fulfil their duties 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 can work towards eliminating discrimination, advancing equality of opportunity and fostering 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:

- disabled people, including people with hearing impairments
- lesbian, gay, bisexual and transgender people
- men
- older people
- people from black, Asian and minority ethnic groups, including those for whom English is not their first language
- people with caring commitments
- people from deprived communities, including those who are on low incomes, unemployed or homeless
- people with learning disabilities[27]
- people in prison or in contact with the criminal justice system
- refugees and asylum seekers
- serving and ex-serving armed forces personnel.

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 18s
- 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.[21] 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 ethnic minority 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 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.[28]
- 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 Bite-sized Positive Practice Guides

IAPT positive practice guides have been developed to support commissioners and providers to improve equity of experience, access and outcomes for a number of specific underrepresented groups. Alongside these full guides, a suite of bite-sized versions have been developed (see Appendix G). The Bite-sized Positive Practice Guides capture the key considerations and recommendations for reducing barriers to access and for adaptations that may be required for each specific group. This should be considered alongside wider best practice set out in this chapter, to provide inclusive and equality-focused services that benefit all people. Below is a summary of the underrepresented groups covered within these guides.

10.3.1 Long-term conditions (LTCs)

This guidance sets out important considerations for working with people with comorbid LTCs, a key requirement in the expansion of IAPT services. Comorbid LTCs and depression and/or anxiety disorders can have a life-changing impact and result in increased use of healthcare services and increased physical healthcare costs. For these reasons, it is imperative that both mental and physical health care needs are met.

10.3.2 Perinatal mental health problems

Undiagnosed depression and anxiety disorders can seriously impact 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. The current guidance sets out key important considerations as outlined in the Antenatal and Postnatal Mental Health NICE guideline, and provides further information on understanding the needs of parents with perinatal health problems and ways in which barriers to access can be minimised.

10.3.3 Learning disabilities

People with learning disabilities can benefit from IAPT services. This guidance seeks to clarify the considerations and reasonable adjustments required to ensure that equitable access to NICE-recommended therapies can be achieved for this underrepresented group.

10.3.4 Autism

People with an autism spectrum condition (ASC) more commonly experience periods of depression and anxiety disorders. From this understanding, it would be expected that adults with an ASC frequently access IAPT services for support. However, this is not the case. People with an ASC typically experience challenges accessing IAPT for reasons such as

difficulties with social interaction and communication, and rigid behaviours and routines. In addition to this they may have sensory needs, for example sensitivity to noise. Guidance currently under development seeks to clarify the considerations and reasonable adjustments required to ensure that equitable access to NICE-recommended therapies can be achieved for this underrepresented group.

10.3.5 Veterans

The Armed Forces Covenant sets out the nation's commitment to armed forces personnel, their families and veterans. The Bite-sized Positive Practice Guide seeks to capture the key considerations and recommendations for reducing barriers to access and adaptations that may be required.

10.3.6 Offenders

These guides provide key considerations and recommendations for reducing barriers to access and adaptations that may be required when working with people in contact with the criminal justice system. There are two bite-sized guides: Working with Offenders in Prison and Working with Offenders in the Community.

10.3.7 Older people

Improving access for older people remains a priority for all services. This guide provides key considerations and recommendations for reducing barriers to access and adaptations that may be required when working with older people, and includes links to more detailed information that services may find of use.

10.3.8 People from minority ethnic communities

People from minority ethnic backgrounds have traditionally been underrepresented in IAPT services, and for most groups their clinical outcomes less good compared with people from White British backgrounds. Every service should take robust anti-racist and inclusion action to tackle and overcome these disadvantages. This guide covers key factors to improve equity of access and outcomes for ethnic minority communities.

10.3.9 Working with people who use drug and alcohol

This guidance seeks to assist IAPT teams to work confidently and inclusively with those who use drink and/or drugs alongside their common mental health problems and have a presentation that can be appropriately treated in IAPT. It captures key considerations and recommendations for reducing barriers to access and adaptations that may be required to tackle and overcome the disadvantages faced by this group.

Work continues to update current guides and on the production of further guides to support commissioners and providers to improve equity of experience, access and outcomes for underrepresented groups. As guides are updated and additional guides are developed, revisions to the manual will be made.

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.[29] This is further supported by The NHS Long Term Plan which sets to build on the provision of genuinely integrated care for people at the point of delivery.

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.[30] Therefore, it is good practice for IAPT services to be commissioned as part of a wider system.[27] 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

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:

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

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
- increasing capacity to respond at an earlier stage
- forming part of a comprehensive relapse prevention package.

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

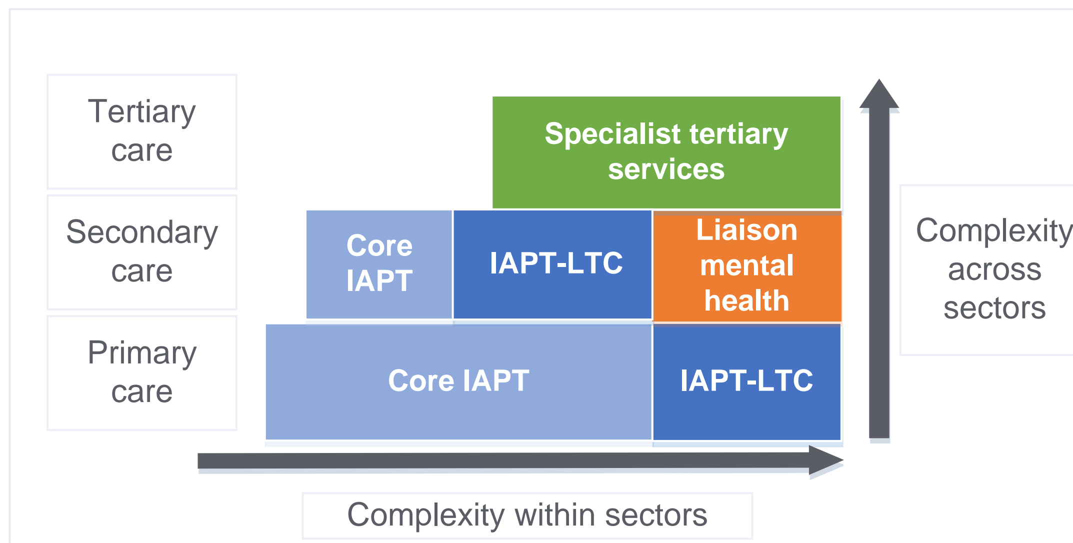
In 2016, NHS England published Implementing the Five Year Forward View for Mental Health, which committed to parity of esteem for mental and physical health. By 2023/24, 1.9 million people will access IAPT. Of the additional 980,000 people seen, two thirds will have coexisting physical health conditions 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 and MUS, through skill-sharing and treating the 'whole person' to optimise outcomes. This will help overcome barriers to the recognition and treatment of mental health problems in people 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 are required to develop and deliver a new model through integration with physical health care services.

Figure 6: Integrated delivery of care



The Improving Access to Psychological Therapies (IAPT) Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms: Full implementation guidance covers the next important step in the development of the IAPT programme. The guidance summarises current knowledge about how to set up and run IAPT-LTC services and, alongside The IAPT Manual, encourages commissioners and clinicians to use local and national data to better understand the strengths and limitations of their evolving service.

11.3 Primary care interface

The proposals in the General Practice Forward View outline an ambition for 3,000 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.[34] 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 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.[32] 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.

Senior employment advisers aim 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 coordinators generally operate at a strategic level and do not have a caseload but can complement and support the work of hands-on employment advice services.

11.6 Debt advice

The link between mental health problems and debt is well established. For Money and Pension Service-funded debt advice services, 56% of debt advice clients had been diagnosed with a mental health problem (2018–19). The Money and Mental Health Policy Institute state that half (46%) of people in problem debt also have a mental health problem, and that being in debt impacts on recovery. For example, people with depression and problem debt are 4.2 times more likely to still have depression 18 months later compared with people without financial difficulty.

IAPT staff should encourage clients to seek free debt advice, if this is identified as a need. Free, quality debt advice can be found using the Money and Pension Service Debt Advice Locator Tool.

Staff can use the tool or signpost patients to this, to identify online or telephone debt advice providers, depending on the preference of the individual who needs advice. A postcode can be used to find a local face-to-face debt advice service if that is what the individual prefers.

Debt advice providers will work with individuals to understand their financial situation and encourage a debt solution suitable to the patient’s circumstances. This work can continue in parallel with IAPT interventions.

11.7 Student services

Mental health problems are common in student populations. Students may be registered with a GP either at their term-time address or where they live during university vacations. It is important that students have access to IAPT services throughout the year regardless of where their GP is. IAPT services should ensure that this does not impact on the student being able to access/continue treatment.

Features that are likely to help students benefit from IAPT services are:

- Assessment and treatment protocols to provide students with equitable access to treatment, especially in areas with high student populations.
- IAPT staff being aware of the dates of student terms.
- Protocols that allow treatment to continue both during and outside of term-time (using telephone, video conferencing or other internet-based sessions). The IAPT service, linked to the student's main GP, should ensure that treatment is available throughout the full year.
- IAPT services should have 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.
- Agreement with universities to have information about IAPT services and self-referral routes available on the university website.
- Collaborative arrangements with university counselling services to agree which types of mental health problems are best dealt with in house or by the IAPT service.

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.[33]
- **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 are 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 with more complex presentations will generally require more intensive treatment. The same applies to patients with PTSD and social anxiety disorder because NICE does not recommend low-intensity treatment as first choice options for these conditions. 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 builds on the standards promoted by the National Audit of Psychological Therapies. Services measuring against the Accreditation Programme for Psychological Therapies Services 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.
- Continually 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 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

CQC domain	Key features of a better performing IAPT service
	• **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.[35] 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 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

CQC domain	Key features of a better performing IAPT service
	• 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

CQC domain	Key features of a better performing IAPT service
	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 systems • 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

CQC domain	Key features of a better performing IAPT service
	has access to an interpreter or British Sign Language 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 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 The IAPT Manual requirements for IAPT workforce

The IAPT Manual[r] (section 4.1) 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 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).[s] All clinicians should be accredited by relevant professional bodies and 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, with linked professional registration with the relevant professional body following training. 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.*

---

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

[s] 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.

High-intensity workforce

High-intensity therapists deliver a range of [Step 3](#) NICE-recommended evidence-based therapies, outlined in Table 3.[t] *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. NICE recommends five different high-intensity therapies for depression (CBT, IPT, brief psychodynamic therapy, counselling for depression and couple therapy).*

In addition to offering CBT, commissioners and providers should ensure patients with depression (who comprise about 40% of referrals) are provided with a meaningful choice of high-intensity therapies. To make this possible, it is recommended that between 10% and 30% of a service's total high-intensity workforce (WTEs) comprises individuals who have been trained to deliver depression treatments other than CBT. Staff proportions towards the higher end of this range would be appropriate if the service aims to have substantial capacity in multiple non-CBT therapies. The lower end of the range is more appropriate if only one non-CBT therapy is offered. All services are expected to have capacity to offer couple therapy to individuals who are depressed in the context of a relationship issue and have a partner who is willing to work with the patient in therapy.'

3 Training and accreditation requirements

3.1 Psychological wellbeing practitioners

3.1.1 Training requirement for entry

All psychological wellbeing practitioners (PWPs in Adult IAPT) 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.
The only exception to this will be those who have completed:

- the Health Education England (HEE) commissioned 2021 'PWP Assessment of Competence Scheme'.
    - This offers a one-off opportunity to assess competence of those who were already working in IAPT services as PWPs by January 2020 but who had not completed a BPS-accredited programme.
- The forerunner trainings in 2005–08 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 graduates of the following programme with evidence of either MSc or PGCert award during the period 2005–08:
    - 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;
    - 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 2005–08

Trainee PWPs 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

[t] Not reproduced here.

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.

3.1.2 Accreditation and maintaining competence

PWPs are expected to maintain continuous individual registration of the type set out in Table 1. Registration 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. In addition, PWPs should maintain and develop skills through regular CPD as set out in the PWP Training Review (2015)[u] and the IAPT Guidance on Preceptorship and Continuing Professional Development for Psychological Wellbeing Practitioners.

3.2 High-intensity therapists

3.2.1 Training requirement for entry

High-intensity therapists working in IAPT services should either:

- Have 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 1 year of qualifying, **or**
- Have the recognised individual accreditation to deliver the therapy or therapies that they deliver in IAPT.

3.2.2 Accreditation and 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. 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 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 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

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

alone until they are registered as trainees or have their accreditation in place.

3.4 Other roles

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, research assistants, assistant psychologists and newer roles such as assistant 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 9. However, some of the roles will be instrumental in making these therapies and PWP interventions as accessible and efficiently provided as possible.

Table 9: Recognised qualifications and individual accreditations for clinicians in IAPT services

Therapy type	Explanation of NICE-recommended therapy type	IAPT training curriculum	IAPT training entry requirement	Training accredited by	Required post-training individual accreditation	Practitioners must have the following to practice:
Guided self-help based on the principles of CBT	Low-intensity psychosocial interventions	Curriculum for Low-Intensity Therapies Workers	Graduates of any discipline who can demonstrate that they meet the academic requirements of a post graduate level qualification. Those without a degree, undertaking the level 6 apprenticeship route, require relevant experience and qualifications	BPS	BABCP or BPS Registration	Accredited IAPT PWP training and individual BABCP or BPS registration and experience with adults with anxiety and depression
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

Therapy type	Explanation of NICE-recommended therapy type	IAPT training curriculum	IAPT training entry requirement	Training accredited by	Required post-training individual accreditation	Practitioners must have the following to practice:
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)	IAPT specified counselling or psychotherapy accreditation[v] Health and Care Professions Council (HCPC) registered practitioner psychologist	BACP	IAPT specified counselling or psychotherapy accreditation[u] HCPC registered practitioner psychologist	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 Couple Therapy (BCT) for Depression	CTfD curriculum: IAPT Specified counselling or psychotherapy accreditation[v]/ HCPC registered practitioner psychologist BCT curriculum: BABCP Accredited	Tavistock Relationships/ British Association for Behavioural and Cognitive Psychotherapies	CTfD curriculum: IAPT Specified counselling or psychotherapy accreditation[u]/ HCPC registered practitioner psychologist BCT curriculum: BABCP Accredited	Accredited IAPT CTfD/BCT training and individual accreditation
Brief dynamic interpersonal therapy (DIT)	Brief psychodynamic psychotherapy developed for treating depression. It	Revised (20-day) Curriculum for High-Intensity Brief Dynamic Interpersonal	IAPT specified counselling/ psychotherapy accreditation[v]/ HCPC registered practitioner	British Psychoanalytic Council (BPC)	IAPT specified counselling/ psychotherapy accreditation[u]/ HCPC registered practitioner	Accredited IAPT DIT training and individual accreditation

[v] IAPT specified counselling or psychotherapy accreditations: British Association for Counselling and Psychotherapy (BACP) Accredited; United Kingdom Council for Psychotherapy (UKCP) Registered as a Psychotherapist or Psychotherapeutic Counsellor; Association of Christian Counsellors Accreditation; National Counselling Society Accredited Professional registrants, British Psychoanalytic Council Registered.

Therapy type	Explanation of NICE-recommended therapy type	IAPT training curriculum	IAPT training entry requirement	Training accredited by	Required post-training individual accreditation	Practitioners must have the following to practice:
	includes a focus on difficult things in the past that continue to affect the way people feel and behave in the present	Therapy (DIT)[w]	psychologist		psychologist	
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)	IAPT Specified counselling/ psychotherapy accreditation[v]/ BABCP accredited/ General Medical Council registered Psychiatrist/ HCPC registered practitioner psychologist or arts therapist	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.	Curriculum for Mindfulness- based Cognitive Therapy (IAPT MBCT)	BABCP Accredited	To be registered with the British Association of Mindfulness-based Approaches (BAMBA)	BAMBA register of Mindfulness Teachers	Recognised IAPT MBCT Training and on BAMBA register of Mindfulness Teachers **OR** on BAMBA register of

[w] The 5-day National Curriculum in Dynamic Interpersonal Therapy (DIT) is a recognised qualification for DIT practitioners who started this training prior to 31 March 2020. Post 31 March 2020, the 5-day training can only be undertaken by those who can evidence an extensive background in psychodynamic psychotherapy in training and supervised practice, to enable them to join the IAPT workforce.

Therapy type	Explanation of NICE-recommended therapy type	IAPT training curriculum	IAPT training entry requirement	Training accredited by	Required post-training individual accreditation	Practitioners must have the following to practice:
	Treatment is often delivered in groups and starts after an initial intervention for an acute episode has been completed					Mindfulness Teachers **AND** have undertaken and passed an assessment of MBCT competence to an equivalent standard as required in the IAPT MBCT training[x])

[x] IAPT staff who have worked continually in IAPT as MBCT teachers since before 1 January 2021 can also have equivalence for IAPT practice recognised through BAMBA's grandparenting scheme.

Definitions of terms and abbreviations

Definitions of terms

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, COPD, 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 IBS.
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[y] 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.

[y] 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

Abbreviations

ADSM	Anxiety disorder specific measure
APMS	Adult Psychiatric Morbidity Survey
AFV	Armed Forces Veteran
ASC	Autism spectrum condition
BABCP	British Association for Behavioural and Cognitive Psychotherapies
BAMBA	British Association of Mindfulness- based Approaches
BCT	Behavioural couple therapy
BIQ	Body Image Questionnaire
CBT	Cognitive behavioural therapy
CCG	Clinical commissioning group
CFQ	Chalder Fatigue Questionnaire
COPD	Chronic obstructive pulmonary disease
CPD	Continuing professional development
CQC	Care Quality Commission
CTfD	Couple Therapy for Depression
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th edition
EMDR	Eye movement desensitisation and reprocessing
FAQs	Frequently asked questions
GAD-7	Generalised Anxiety Disorder Scale – 7 items
GP	General practitioner
HCPC	Health and Care Professions Council
HEE	Health Education England
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
ICD-10	International Statistical Classification of Diseases and Related Health Problems 10th edition
IPT	Interpersonal psychotherapy
IT	Information technology
LGBT	Lesbian, gay, bisexual and transgender
LTC	Long-term physical health condition
MBCT	Mindfulness-based cognitive therapy
MI	Agoraphobia-Mobility Inventory

MUS	Medically unexplained symptoms
NCCMH	National Collaborating Centre for Mental Health
NICE	National Institute for Health and Care Excellence
OACMHT	Older Adult Community Mental Health Team
OCD	Obsessive-compulsive disorder
OCI	Obsessive-Compulsive Inventory
OWG	Older Adults Overcoming Worry Group
PCL-5	Posttraumatic Checklist
PDSS	Panic Disorder Severity Scale
PEQ	Patient experience questionnaire
PHQ-9	Patient Health Questionnaire – 9 items
PHQ-15	Patient Health Questionnaire – 15 items
PPiMH	Positive Practice in Mental Health Collaborative
PTL	Patient Tracking List (or Patient Target List or Priority Tracking List)
PTSD	Post-traumatic stress disorder
PWP	Psychological wellbeing practitioner
RCT	Randomised controlled trial
SPIN	Social Phobia Inventory
UCL	University College London
WTE	Whole-time equivalent
WSAS	Work and Social Adjustment Scale

References

[1] Mental Health Taskforce. The Five Year Forward View For Mental Health. London: NHS England; 2016.

[2] McManus S, Bebbington P, Jenkins R, Brugha T. Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital; 2016.

[3] Pooler A, Beech R. Examining the relationship between anxiety and depression and exacerbations of COPD which result in hospital admission: a systematic review. International Journal of Chronic Obstructive Pulmonary Disease. 2014;9:315-30.

[4] Layard R, Clark D. Thrive: The Power of Evidence-based Psychological Therapies. London: Penguin: UK 2014.

[5] Naylor C, Das P, Ross S, Honeyman M, Thompson J, Gilburt H. Bringing Together Physical and Mental Health. London: King's Fund; 2016.

[6] Laurin C, Moullec G, Bacon SL, Lavoie KL. Impact of anxiety and depression on chronic obstructive pulmonary disease exacerbation risk. . American Journal of Respiratory and Critical Care Medicine. 2012;185:5.

[7] Konnopka A, Kaufmann C, König H, Heider D, Wild B, Szecsenyi J, et al. Association of costs with somatic symptom severity in patients with medically unexplained symptoms. Journal of Psychosomatic Research. 2013:370-75.

[8] Burton C, McGorm K, Richardson G, Weller D, Sharpe M. Healthcare costs incurred by patients repeatedly referred to secondary medical care with medically unexplained symptoms: a cost of illness study. Journal of Psychosomatic Research. 2012;72:242-47.

[9] Knapp M, McDaid D, Parsonage M. Mental Health Promotion and Mental Illness Prevention: the Economic Case. London: Department of Health; 2011.

[10] Allen L, Woolfolk R, Escobar J, Gara M, Hamer R. Cognitive-behavioral therapy for somatization disorder. A randomized controlled trial Archives of Internal Medicine. 2006;166:1512-8.

[11] Howard C, Dupont S, Haselden B, Lynch J, Wills P. The effectiveness of a group cognitive behavioural breathlessness intervention on health status, mood and hospital admissions in elderly patients with chronic obstructive pulmonary disease. Psychology, Health and Medicine. 2010;15:371-85.

[12] Organisation for Economic Co-operation and Development. Making Mental Health Count: The social and economic cost of neglecting mental health care. OECD Health Policy Studies. Paris: OECD Publishing 2014.

[13] Rush AJ, Beck AT, Kovacs M, Hollon S. Comparative efficacy of cognitive therapy and pharmacotherapy in the treatment of depressed outpatients. Cognitive Therapy and Research. 1977;1:17-37.

[14] NICE Posttraumatic Stress Disorder (NG116). London: NICE; 2018.

[15] NICE Social anxiety disorder: recognition, assessment and treatment (CG159). London: NICE; 2018.

[16] Geier TJ, Hunt JC, Hanson JL, Heyrman K, Larsen SE, Brasel KJ, deRoon-Cassini TA. Validation of abbreviated four- and eight-item versions of the PTSD checklist for DSM-5 in a traumatically injured sample. Journal of Traumatic Stress. 2020; 33; 218-226.

[17] Connor KM, Kobak KA, Churchill LE, Katzelnick D, Davidson JR. Mini-SPIN: a brief screening assessment for generalized social anxiety disorder. Depression and Anxiety. 2001; 14; 137- 140.

[18] Clark D, Layard R, Smithies R, Richards D, Suckling R, Wright B. Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. . Behaviour Research and Therapy. 2009; 47:910-20.

[19] NHS England. Improving Access to Psychological Therapies (IAPT) Waiting Times Guidance and FAQ's. London: NHS England; 2015.

[20] Gyani A, Shafran R, Layard R, Clark DM. Enhancing recovery rates: Lessons from year one of IAPT. Behaviour Research and Therapy. 2013;51:9.

[21] NICE. Common mental health problems: identification and pathways to care. London: NICE; 2011.

[22] Clark DM, Canvin L, Green J, Layard R, Pilling S, Janecka M. Promoting public transparency about the outcomes of mental health services: the IAPT approach and what it reveals about the how services should be organized Lancet. in press.

[23] Langley G, Moen R, Nolan K, Nolan T, Norman C, Provost L. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance. 2nd edn. California: Jossey-Bass Publishers; 2009.

[24] Pimm J. Plan, Do, Study, Act: a methodology for enhancing recovery in your service. Regional conference on enhancing recovery in IAPT services2016; Birmingham, UK.

[25] Hollon S, Stewart M, Strunk D. Enduring effects for cognitive behavior therapy in the treatment of depression and anxiety. Annual Review of Clinical Psychology. 2006.;57:285-315.

[26] Ali S, Rhodes L, Moreea O, McMillan D, Gilbody S, Leach C, et al. How durable is the effect of low intensity CBT for depression and anxiety? Remission and relapse in a longitudinal cohort study. Behaviour Research and Therapy. 2017;94:1-8.

[27] England N. Commissioning Talking Therapies for 2011/12 Issue 3. London: NHS England; 2011.

[28] NICE. Commissioning stepped care for people with common mental health disorders. London: NICE; 2011.

[29] NHS England. Next steps on the NHS Five Year Forward View. London: NHS England; 2017.

[30] Naylor C, Taggart H, Charles A. Mental health and new models of care: lessons from the vanguards. London: The King's Fund, Royal College of Psychiatrists; 2017.

[31] Baird B, Charles A, Honeyman M, Maguire D, Das P. Understanding pressures in general practice. London: King's Fund; 2016.

[32] NICE. Depression in Adults with a Chronic Physical Health Problem: Recognition and Management. NICE Clinical Guideline 91. Available from: www.nice.org.uk/guidance/cg91. London: NICE; 2009.

[33] Department of Health. Commissioning a Brighter Future: Improving Access to Psychological Therapies - positive practice guide. London: Department of Health; 2007.

[34] Taunt R, Allcock C, Lockwood A. Need to nurture: outcomes-based commissioning in the NHS. London: The Health Foundation; 2015.

[35] NHS Digital. Psychological therapies: annual report on the use of IAPT services in England (2015-16). Leeds, UK; 2016.

APPENDICES AND HELPFUL RESOURCES

Appendix A: NICE-recommended care 89
Appendix B: Competence frameworks 90
Appendix C: IAPT screening prompts 95
Appendix D: Clinical cut-offs and reliable change 97
Appendix E: Examples of patient tracking lists (PTLs) 98
Appendix F: Development team 100
Appendix G: Bite-sized Positive Practice Guides 101
Appendix H: Helpful resources 116
H.1 Positive practice examples 117
H.2 Case identification tools 127
H.3 Outcome measures 128
H.4 Web-based resources 155

Appendix A: NICE-recommended care

The evidence base underpinning the use of psychological therapies in the treatment of **depression and anxiety disorders** can be found in the following NICE guidance:

- Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance (NICE clinical guideline 192)
- Common Mental Health Problems: Identification and Pathways to Care (NICE clinical guideline 123)
- Depression in Adults: Recognition and Management (NICE clinical guideline 90)
- Depression in Adults with a Chronic Physical Health Problem: Recognition and Management (NICE clinical guideline 91)
- Generalised Anxiety Disorder and Panic Disorder in Adults: Management (NICE clinical guideline 113)
- Obsessive-compulsive Disorder and Body Dysmorphic Disorder: Treatment (NICE clinical guideline 31)
- Post-traumatic Stress Disorder: Management (NICE clinical guideline 26)
- Social Anxiety Disorder: Recognition, Assessment and Treatment (NICE clinical guideline 159)

NICE has also issued guidelines on medically unexplained symptoms (**MUS**) and **multimorbidity**:

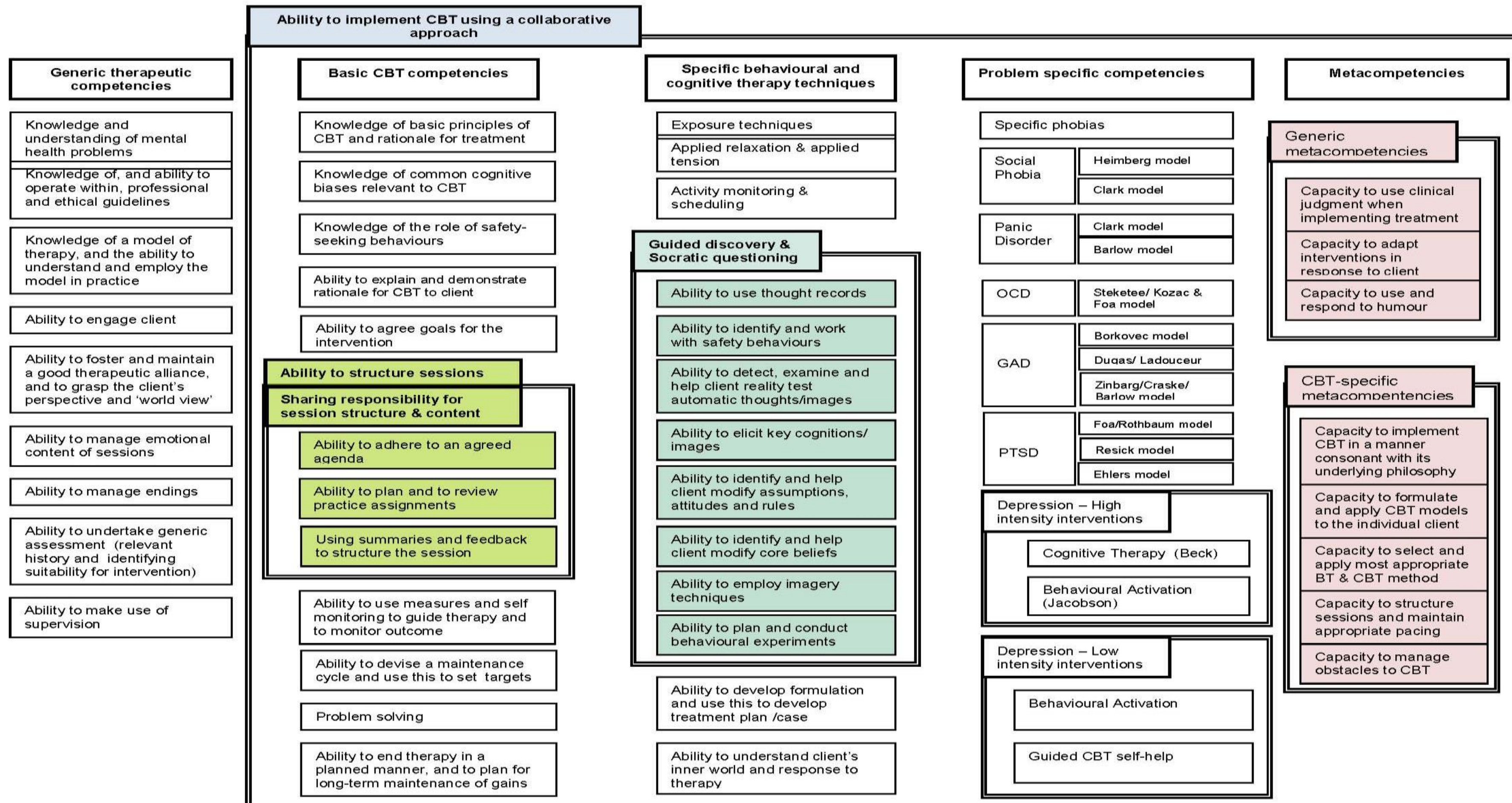
- Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (or Encephalopathy): Diagnosis and Management (NICE clinical guideline 53)
- Chronic Pain (Primary and Secondary) in Over 16s: Assessment of all Chronic Pain and Management of Chronic Primary Pain (NICE guideline NG193)
- Irritable Bowel Syndrome in Adults: Diagnosis and Management (NICE clinical guideline 61)
- Low Back Pain and Sciatica in over 16s: Assessment and Management (NICE guideline 59)
- Multimorbidity: Clinical Assessment and Management (NICE guideline 56)

Information on the physical treatments for long-term physical health conditions (LTCs) and treatment of individual mental health problems can be found on the NICE website.

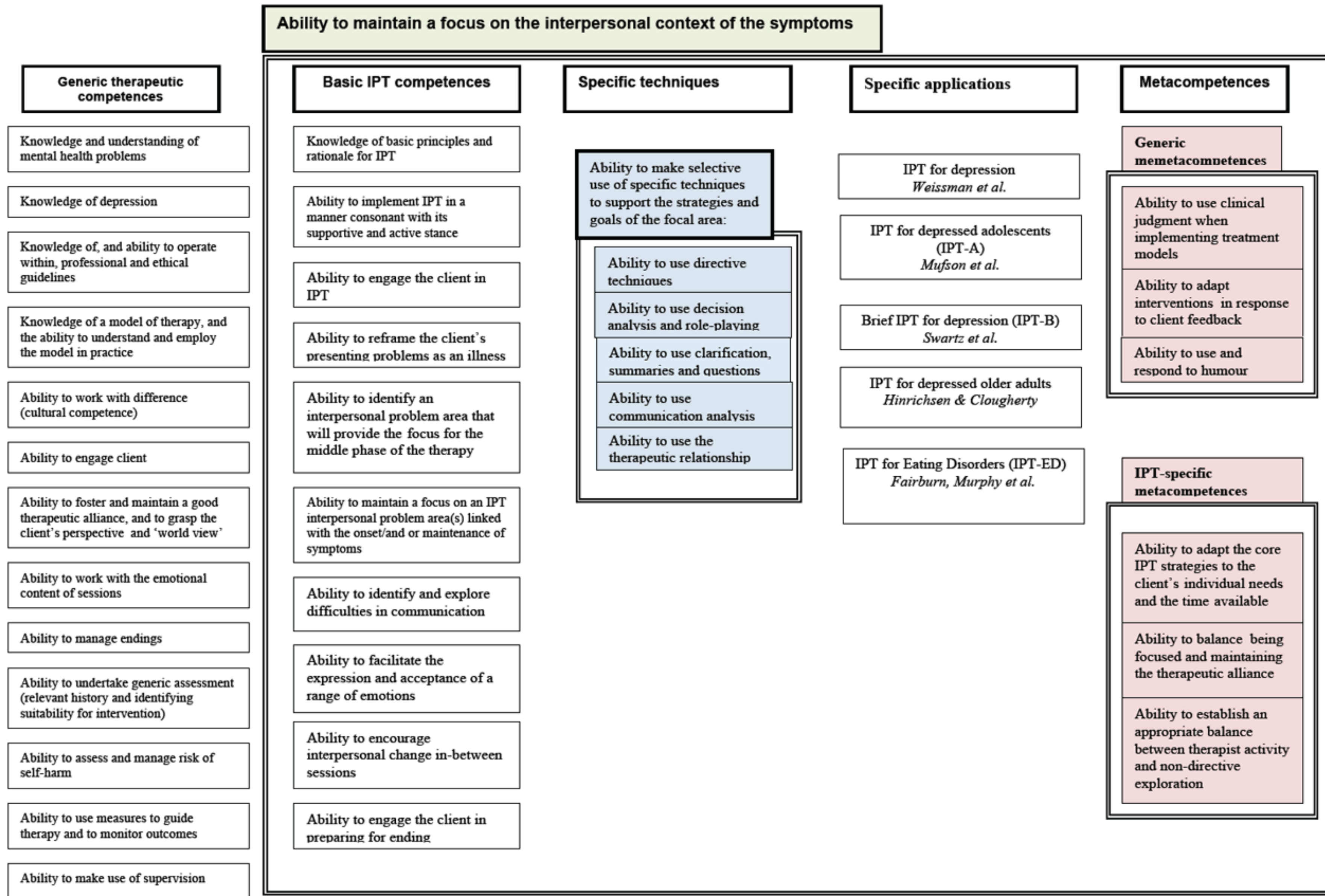
Appendix B: Competence frameworks

The key skills required to deliver NICE-recommended psychological therapies effectively within IAPT services are summarised in the frameworks below. More detailed information about the skills can be found on the UCL website.

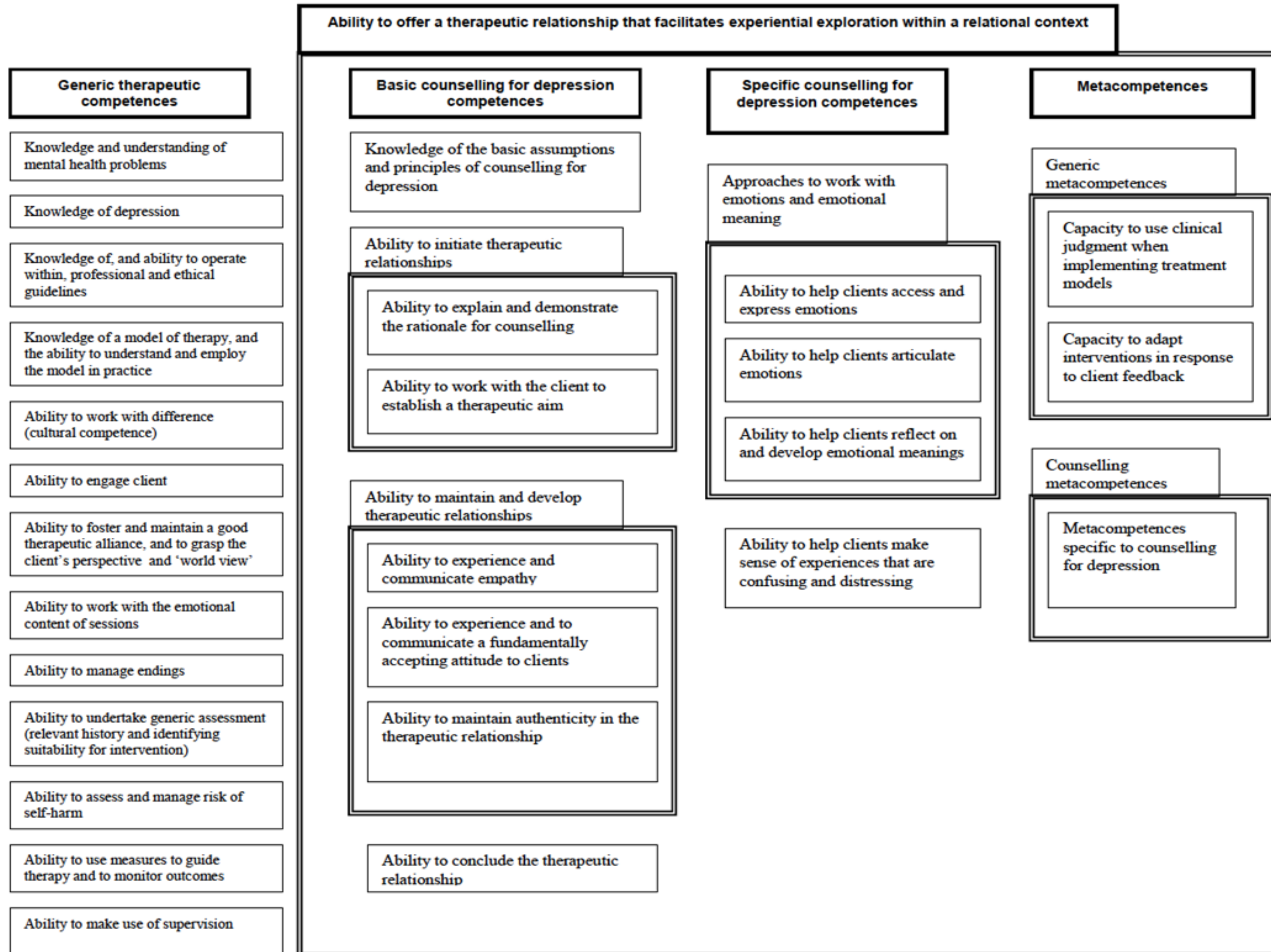
CBT competences:



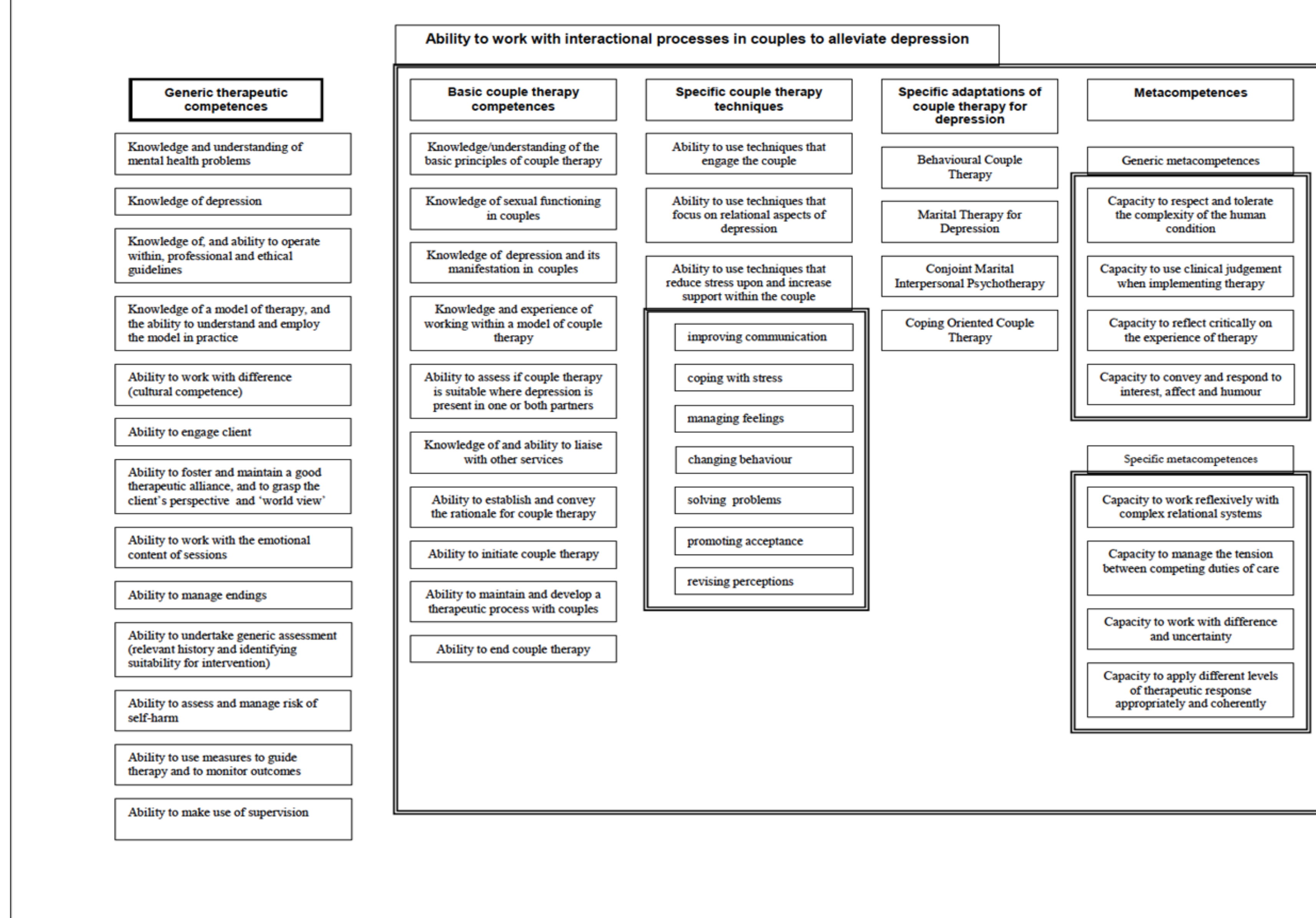
IPT competences:



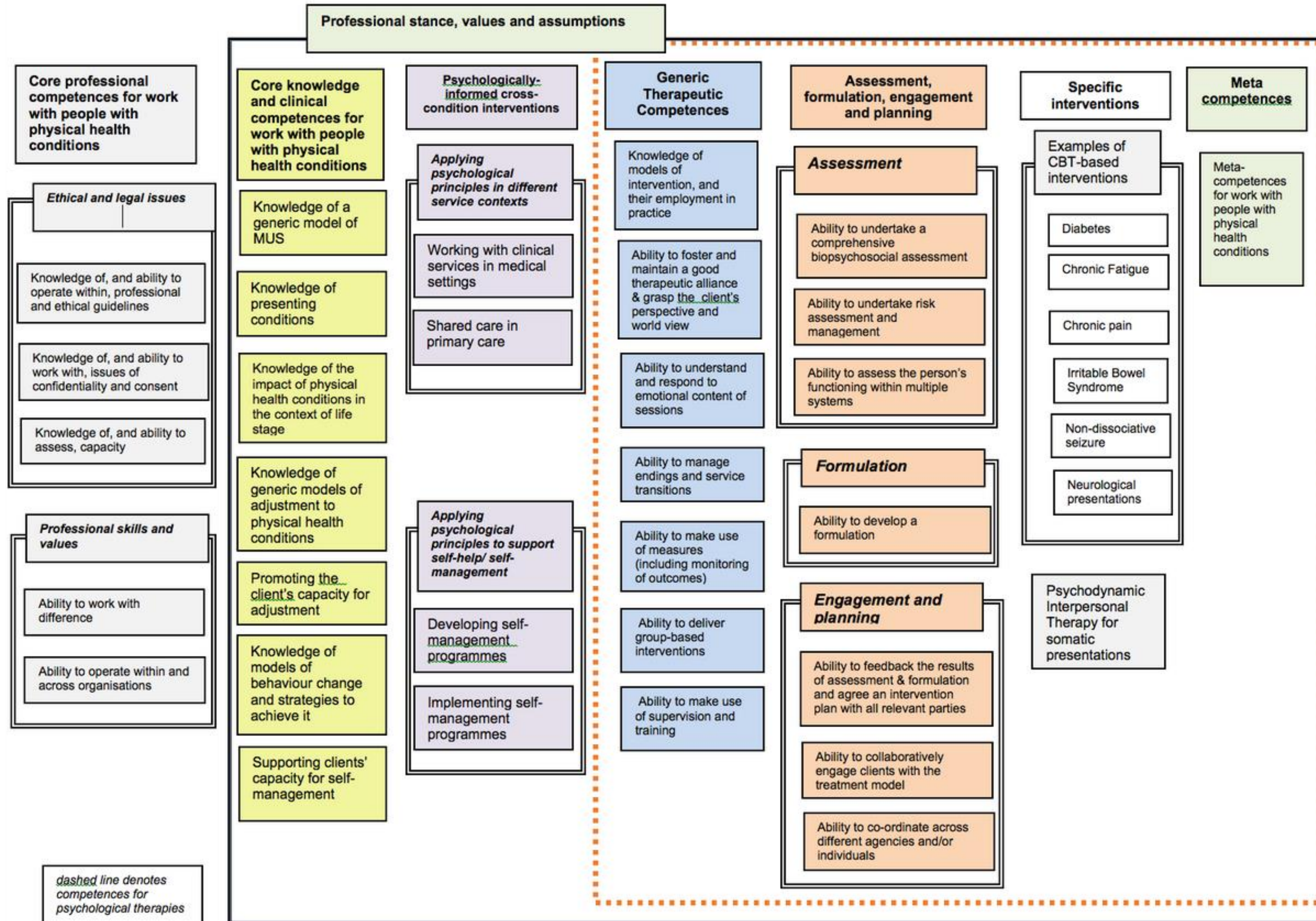
Counselling for depression competences:



Couple therapy for depression competences:

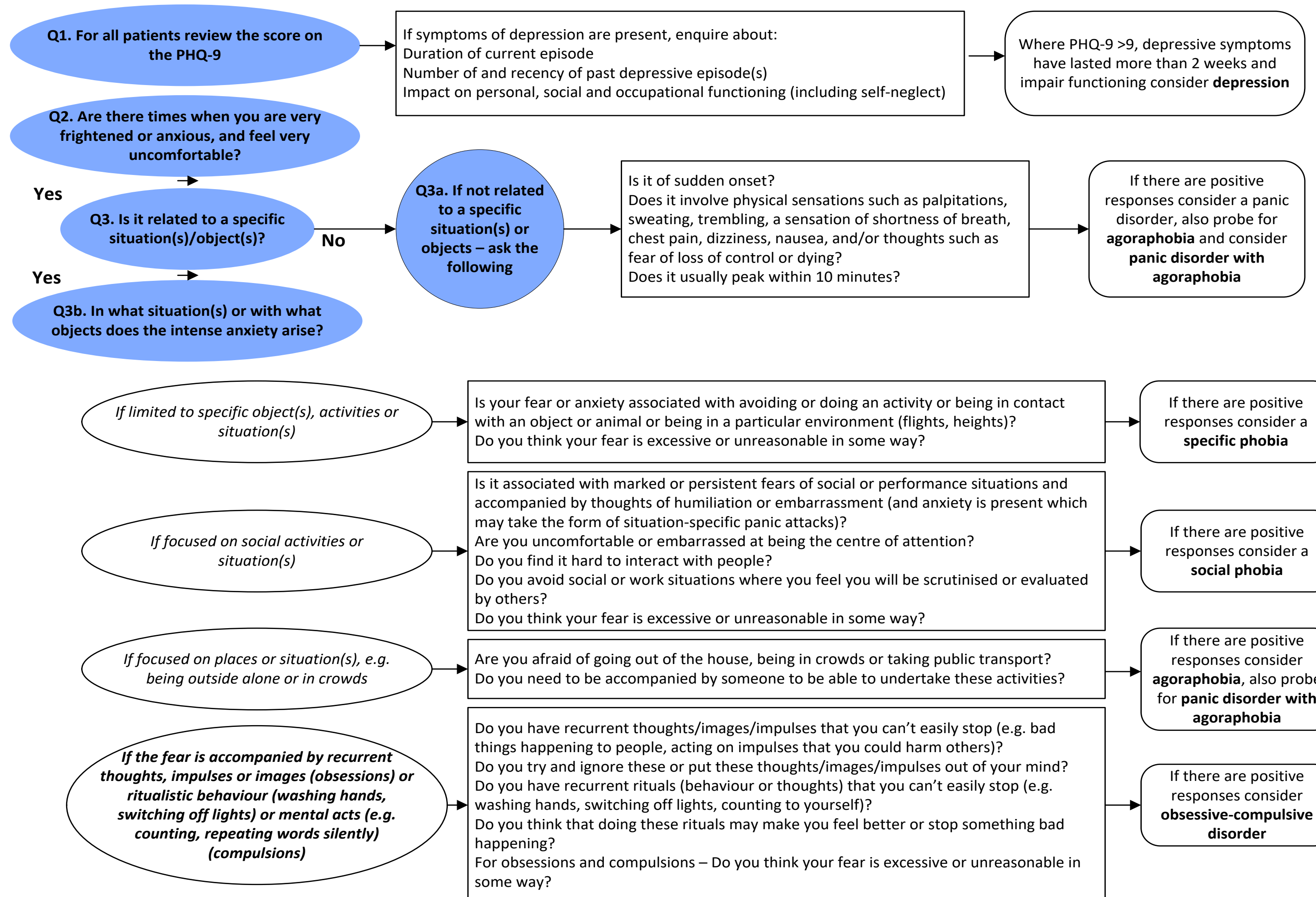


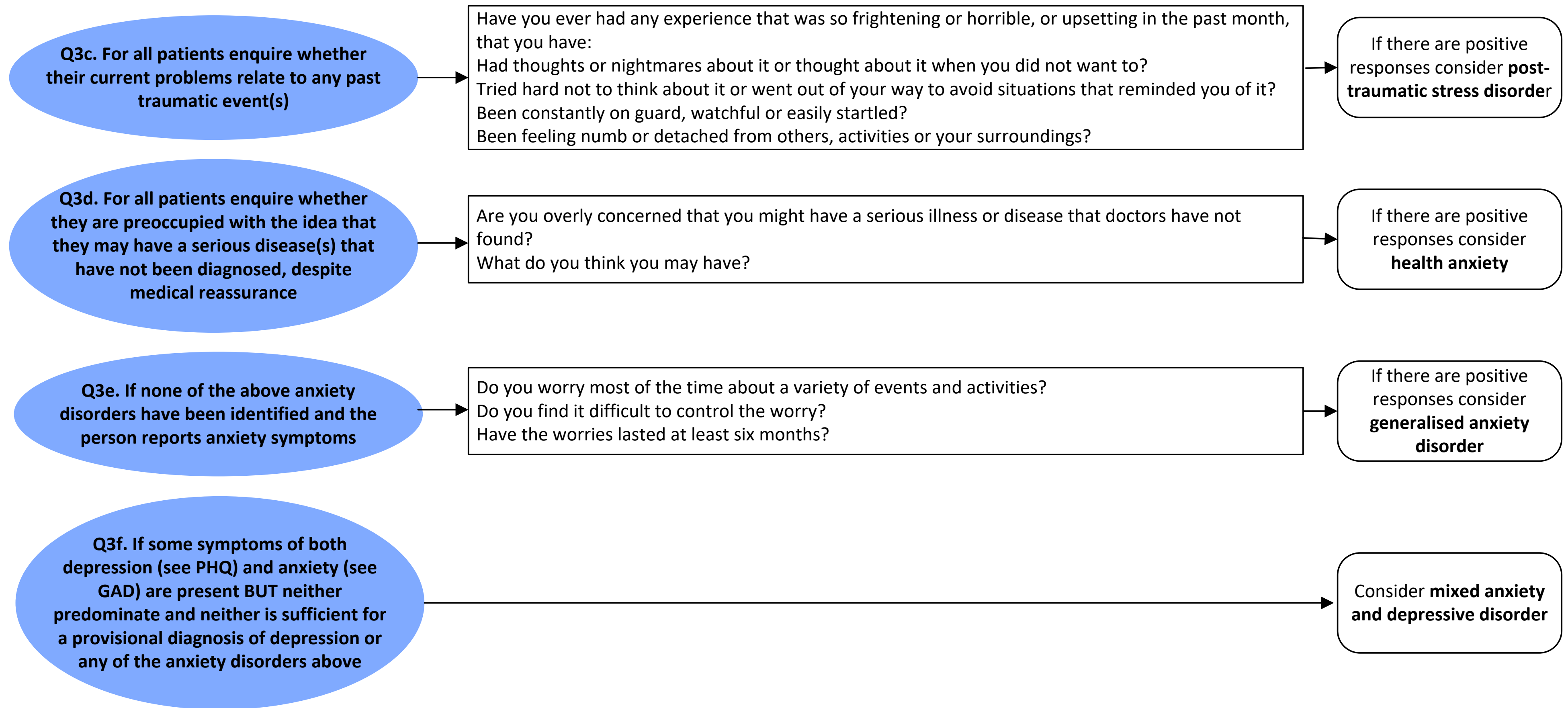
LTC/MUS competences:



Appendix C: IAPT screening prompts

The following prompts are recommended for use in IAPT intake assessments to ensure that a person's clinical problems are identified correctly. Interviewers should cover **all** the prompts, rather than stopping the interview when the first clinical problem is identified. It is very common for people who present with depression to have an underlying anxiety disorder that can be identified with the prompts later in the sequence.




Q3c. For all patients enquire whether their current problems relate to any past traumatic event(s)
Have you ever had any experience that was so frightening or horrible, or upsetting in the past month, that you have:
Had thoughts or nightmares about it or thought about it when you did not want to?
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
Been constantly on guard, watchful or easily startled?
Been feeling numb or detached from others, activities or your surroundings?
If there are positive responses consider post-traumatic stress disorder
Q3d. For all patients enquire whether they are preoccupied with the idea that they may have a serious disease(s) that have not been diagnosed, despite medical reassurance
Are you overly concerned that you might have a serious illness or disease that doctors have not found?
What do you think you may have?
If there are positive responses consider health anxiety
Q3e. If none of the above anxiety disorders have been identified and the person reports anxiety symptoms
Do you worry most of the time about a variety of events and activities?
Do you find it difficult to control the worry?
Have the worries lasted at least six months?
If there are positive responses consider generalised anxiety disorder
Q3f. If some symptoms of both depression (see PHQ) and anxiety (see GAD) are present BUT neither predominate and neither is sufficient for a provisional diagnosis of depression or any of the anxiety disorders above
Consider mixed anxiety and depressive disorder

Appendix D: Clinical cut-offs and reliable change

Clinical cut-offs and reliable change index

Outcome measure	Caseness – scores listed below are considered clinical cases	Reliable change index
Body Image Questionnaire (BIQ) Weekly*	≥40	≥10
Chalder Fatigue Questionnaire (CFQ)*	≥19	≥5
Francis Irritable Bowel Syndrome (IBS) scale*	≥75	≥50
Generalised Anxiety Disorder – 7 (GAD-7)	≥8	≥4
Health Anxiety Inventory	≥18	≥4
Mobility Inventory (MI)	2.3 per item average	≥0.73
Obsessive-Compulsive Inventory (OCI)	≥40	≥32
Panic Disorder Severity Scale (PDSS)	≥8	≥5
Patient Health Questionnaire -9 (PHQ-9)	≥10	≥6
Patient Health Questionnaire – 15 (PHQ-15)*	≥10	≥7
PTSD Checklist for DSM-5 (PCL-5)	≥32	≥10
Social Phobia Inventory (SPIN)	≥19	≥10

* BIQ, IBS-SSS, CFQ and PHQ-15 have now had their respective reliable change values calculated. Further comms will be issued to confirm when these measures will be used for paired scores and recovery calculations within NHS Digital publications.

Appendix E: Examples of patient tracking lists (PTLs)

The examples given here are for a 6-week standard. The exact format of the PTLs are for local decision, but should include all patients waiting at all stages. The numbers waiting are for illustrative purposes only. The term breach date refers to the wait standard, so a breach occurs when a patient waits longer than the standard (6 weeks).

Where there are exceptionally long waits, there is a need to extend the weeks listed past breach date, to create greater granularity and show the real waits of those patients in weeks.

Whole-service PTL showing patients still waiting for an appointment date

Where patients have an agreed date for their first appointment, the reported waiting time should be the time from the referral date to appointment date.
Where patients do not yet have an agreed date for their first appointment, the reported waiting time should be the time from the referral date to today’s date.

	Before Breach Date						Past Breach Date				
Weeks to/past Breach Date	6–5 Weeks	5–4 Weeks	4–3 Weeks	3–2 Weeks	2–1 Weeks	1–0 Weeks	0–1 Weeks	1–2 Weeks	2–3 Weeks	3–4 Weeks	4+ Weeks
Agreed Date	**4**	**9**	**24**	**20**	**30**	**13**	**4**	**2**	**1**		
No Appointment Date	**18**	**24**	**2**		**2**	**5**	**1**		**3**	**2**	**2**

Whole-service PTL showing waits to different types of first therapy

	Before Breach Date						Past Breach Date				
Weeks to/past Breach Date	6–5 Weeks	5–4 Weeks	4–3 Weeks	3–2 Weeks	2–1 Weeks	1–0 Weeks	0–1 Weeks	1–2 Weeks	2–3 Weeks	3–4 Weeks	4+ Weeks
Step 2	**25**	**19**	**27**	**22**	**10**	**2**	**4**				
IPT	**26**	**27**	**29**	**20**	**6**	**5**	**6**	**4**	**1**		**1**
EMDR	**5**	**6**	**5**	**4**	**3**	**6**	**2**	**1**	**1**	**6**	**13**
CBT	**16**	**14**	**17**	**22**	**6**	**6**	**4**	**3**	**2**		**2**
CfD	**28**	**27**	**32**	**26**	**10**	**6**	**1**	**3**	**1**		
Couples	**11**	**9**	**7**	**9**	**2**		**1**		**1**	**1**	**5**
DIT	**5**	**2**	**1**		**2**	**1**		**1**			

EMDR-only PTL showing waits by different localities

	Before Breach Date						Past Breach Date				
Weeks to/past Breach Date	6–5 Weeks	5–4 Weeks	4–3 Weeks	3–2 Weeks	2–1 Weeks	1–0 Weeks	0–1 Weeks	1–2 Weeks	2–3 Weeks	3–4 Weeks	4+ Weeks
North		**5**	**2**	**2**		**4**	**2**			**6**	**8**
South	**5**	**1**		**2**	**1**	**2**					**4**
East			**2**			**1**					
West			**1**		**2**	**1**		**1**	**1**		**1**

Appendix F: Development team

NCCMH technical team for first version of The IAPT Manual

Steve Pilling (Facilitator), Director, NCCMH; Director, CORE (Centre for Outcomes Research and Effectiveness), UCL

Tom Ayers, Senior Associate Director, NCCMH

Katherine Biddulph, Commissioning Manager, Mental Health, NHS Nottingham City Clinical Commissioning Group

Judith Chapman, Clinical Director, Berkshire Healthcare NHS Foundation Trust

David M. Clark, Professor and Chair of Experimental Psychology, University of Oxford; National Clinical and Informatics Adviser for IAPT

Helen Greenwood, Research Assistant, NCCMH

Kate Lorrimer, Editor, NCCMH

Toni Mank, IAPT Head of Service, Sheffield Health and Social Care NHS Foundation Trust

Kevin Mullins, then Head of Mental Health, NHS England.

Clare Taylor, Associate Director – Quality and Research Development, NCCMH

Conor Whelan, Project Manager, NCCMH

Current NHS England team

Sarah Holloway, Head of Mental Health, NHS England

Xanthe Townend, Programme Lead – IAPT & Dementia, NHS England

David M. Clark, Professor and Chair of Experimental Psychology, University of Oxford; National Clinical and Informatics Adviser for IAPT

Adrian Whittington, National Lead for Psychological Professions, NHSE/I and HEE; IAPT National Clinical Advisor: Education

Jullie Tran Graham, Senior IAPT Programme Manager

Hayley Matthews, IAPT Programme Manager, NHS England

Andrew Armitage, IAPT Senior Project Manager, NHS England

Sarah Wood, IAPT Project Manager, NHS England

Appendix G: Bite-sized Positive Practice Guides

G.1 Working with long-term conditions (LTCs): Bite-sized positive practice guide

Context and considerations

- Mental and physical health are intrinsically linked and chronic physical illness can have a life-changing effect on an individual's wellbeing, functional capability and quality of life.
- Increased rates of depression or anxiety disorders are experienced by people with LTCs or MUS.
  - Two thirds of people with LTCs will also have a mental health problem, mostly depression and anxiety disorders.
  - 70% of people with MUS will experience depression or an anxiety disorder.
  - Higher rates of depression and anxiety disorders can be seen in people with cardiovascular disease, diabetes, COPD and musculoskeletal disorders.
  - In general, when a person has a greater number of LTCs and more marked functional impairment, their mental health tends to be poorer.
- People are even more unlikely to access treatment for their mental health problem when they also have LTCs or MUS.
- Depression and/or anxiety disorders (as either a cause or a consequence of physical illness) may exacerbate physical symptoms and add to the person's distress.
  - Comorbidity of depression and anxiety disorders with LTCs results in increased use of other healthcare services.
  - Healthcare costs for those with coexisting mental health problems and LTCs are significantly (around 50%) higher.
- Left untreated, mental health problems can have a significant impact on the person's physical health and can lead to:
  - Lower likelihood of engaging with treatment for the physical health problem.
  - A reduction in the person's ability to effectively self-manage the problem.
  - Higher likelihood of unhealthy behaviour, for example smoking, drinking and so on.
  - Poorer physical health, including premature mortality.
- A patients' beliefs about their illness and treatment may influence their coping behaviours and, in response to illness symptoms, associated distress and disability.

Reducing barriers to access

- Focus on outreach and engagement of patients and healthcare professionals
  - IAPT services should take time to educate patients and healthcare professionals on the links between LTCs and depression and anxiety disorders, and the benefits IAPT can provide those with LTCs.
  - Local engagement and outreach is essential to raise awareness of IAPT and build an understanding of the support it offers. This can be achieved by connecting with relevant groups, networks and organisations already working with people with LTCs.
  - Dedicated LTC outreach roles should be considered within IAPT services, along with other bespoke outreach initiatives.

    - Efforts should be made to ensure that people who are currently receiving treatment for LTCs in an existing general healthcare pathway are made aware of services IAPT can offer and can self-refer to these.
- It is important to build relationships with physical health professionals as well as GPs.
    - Physical health professionals may be better placed to identify the existence of depression and anxiety and could provide an important referral route to IAPT while any physical health needs are also being addressed.
- Integrate services within physical health pathways
    - With many patients believing that their symptoms are entirely physical problems, a service that is located or embedded in a physical health framework may encourage engagement. Co-located IAPT services ensure that both the physical and mental health problems of the person are addressed simultaneously, support prompt uptake of treatment and decrease the likelihood of non-attendance.
    - Integration supports effective identification and treatment of the person's mental health problem, which can reduce their use of physical health services.
    - Wherever possible, therapists should be co-located with general health care teams and primary care to reduce stigma, support participation in multidisciplinary team meetings, care planning and, where required, joint working.
- Engage the local population in service development
    - Ensure more people who have, or have had, LTCs are involved in all aspects of service development, including clinical work and service management so that IAPT is as accessible as possible for these individuals.
    - Conduct an Equality Impact Assessment to highlight the needs of, and solutions for, specific LTC groups within the local population.

Adaptations to clinical practice

- It is recommended that all clinicians working with LTCs undertake the IAPT-recognised LTC Top-Up Training.
- It is important to have knowledge of the presenting physical health condition/s and receive appropriate supervision with health professionals with disease-specific expertise as required.
- Optimal results are obtained when psychological therapies are delivered to take account of the way LTCs interact with mental health problems and impact on daily functioning.
- It is important to promote the self-management of LTCs throughout treatment.
- Intervention delivery may require modification to take into account the LTC.
- Where relevant, use disease-specific routine outcome measures to aid problem recognition and definition, shared decision-making and review of progress.
- Collaborative and realistic goal setting needs to be in the context of the LTC/s and medical treatment, including consideration of when it may be appropriate to do this jointly with a physical health colleague.
- Practical adaptations to illness and disability such as offering flexible appointments, local and accessible settings for disabled patients, spacing of appointments and pauses in treatment rather than discharge as a means of encouraging patients to stay in treatment while unwell may need to be considered.

Training and resources

The Improving Access to Psychological Therapies (IAPT) Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms: Full implementation guidance.
Competence Framework: Psychological Interventions with People with Persistent Physical Health Problems

To view the full positive practice guide please click here

G.2 Working with Learning Disability: Bite-sized Positive Practice Guide

Context and considerations

- People with learning disabilities are more likely to develop mental health problems than the general population, with around 25–40% of people with learning disabilities having additional mental health needs.
- NICE guidance for common mental health problems apply to those with mild to moderate learning disabilities.
- IQ is not a good way to decide whether someone can or cannot benefit from talking therapies and should not be used as exclusion criteria.
- Many in the general population will have the same characteristics as people with learning disabilities but will not have been formally identified and diagnosed. As such, adaptations help anyone with low ability and literacy and numeracy difficulties.
- People with learning disabilities are a disadvantaged and vulnerable group who are likely to experience barriers to accessing healthcare. Despite poorer health than the rest of the population, access to the NHS is often limited.
- It can be difficult to identify the prevalence of depression and anxiety among people with learning disabilities. They may not be able to express their feelings easily in words, which can mask the clinical presentation of a mental health problem and cause difficulty in making an accurate diagnosis.
- The IAPT Dataset is entirely suitable for people with learning disabilities. However, additional time may be required to read these with the patient.

Reducing barriers to access

- It is important that mental health and learning disability services work collaboratively.
- Learning disability services, family members, carers and advocates can play an important role in identifying mental health problems in people with learning disabilities and should be a key part of the referral pathway into IAPT.
- Advertise and provide psychological therapies in ways that are acceptable and meaningful to people with learning disabilities, providing information in easy-to-understand formats.
- Work with local groups specialising in learning disability to raise awareness of IAPT and the support it can provide people with learning disabilities.
- Ensure people with a learning disability are involved in all aspects of service development, including clinical work and service management so that IAPT is as accessible as possible for this population.
- Support and train people with learning disabilities to become part of the IAPT workforce, benefiting both the service and patients.

- Consider creating roles for staff who are specifically trained and supervised to enable them to work with people with learning disabilities.
- Many people with formally identified learning disabilities are supported by family or paid for carers to a greater or lesser extent. Services should allow these supporters to assist in accessing and remaining engaged with services.
- Consider learning disability champions who can liaise with local learning disability services, facilitate discussions and coordinate adaptations such as training for the IAPT and learning disability services.

Adaptations to clinical practice

- People with learning disabilities may have complex needs such as challenging behaviour and an inability to express themselves using words. IAPT services must be flexible in recognising and responding appropriately to these needs.
- Set up a flagging system at referral stage to highlight that the person has literacy difficulties or a learning disability so that reasonable adjustments can be made from the point of referral.
- Adjustments to the duration and number of sessions should be considered to take account of varying levels of understanding and need.
- Face-to-face appointments are recommended if an individual has significant literacy and numeracy difficulties.
- Enable IAPT staff to access clinical supervision from learning disability services.
- Change wording on the IAPT Data Set only if necessary and then as little as possible, for example, change one word rather than several.
- Break down questions with multiple components and deliver each element one at a time.
- Emphasise less cognitive elements and more behavioural elements within the intervention structure if required.
- Expect a need for repetition and, particularly when there is more than a week between sessions, the need to completely recap skills on a continuous basis.
- The patient could make an audio recording (using a smartphone or similar) of the session, the things to practise or a reminder of their thoughts or emotions.

Training and resources

All staff should be trained to be sensitive to, and aware of, the specific needs of individuals with learning disabilities in line with human rights and disability discrimination law.
A number of resources are available to enhance understanding further:

- Greenlight Toolkit Green_Light_Toolkit_2017.pdf (ndti.org.uk) and Greenlight Toolkit – The Audit Green Light Toolkit - the Audit (office.com)
- Download and use free easy-read CBT materials from www.ucl.ac.uk/psychiatry/cbt
- www.booksbeyondwords.co.uk produces books, eBooks and other resources for people who find it easier to understand pictures than words.
- Making health and social care information accessible (NHS England, 2015): www.england.nhs.uk/ourwork/patients/accessibleinfo-2/
- Image banks with an annual subscription can be found at: www.photosymbols.com/ and www.changepeople.org/
- www.inspiredservices.org.uk provides accessible information, specialising in easy read, Braille, audio, large print and translation services.
- www.easyhealth.org.uk/ can adapt materials into easy read format.

- Free easy read health/mental health information is available from: www.surreyhealthaction.org/

To view the full positive practice guide please click here

G.3 Working with Veterans: Bite-sized Positive Practice Guide

Background and context

- Post-Traumatic Stress Disorder (PTSD) is commonly associated with Armed Forces Veterans (AFVs), but anxiety, depression and problems related to alcohol are more commonly experienced.
- Increased self-sufficiency is a common trait, which may lead to later presentation when symptoms are entrenched.
- AFVs can be more vulnerable to social exclusion including homelessness and unemployment.
- Some deployments (for example, peacekeeping) can lead to increased risk of exposure to moral injury.
- Consideration should be given for the treatment of complex PTSD where exposure to moral injury, combat guilt or shame is identified as a significant factor during assessment.
- AFVs often see trust and loyalty as core values driving their lives. There can be hypersensitivity to 'broken expectations' (sometimes seen as a breach of core values).
- The former service, rank and occupational group of an AFV may be critical considerations, in addition to factors that you would normally consider with any individual including sex, age and ethnicity.

Reducing barriers to access

AFVs may demonstrate a lack of trust in non-military mental health services and have difficulties engaging. Steps to reduce these barriers include:

- Discuss with the AFV how they would like to be referred to, common preferences include 'Armed Forces Veteran' or 'ex-military'.
- Ensure any materials targeted at engaging AFVs with mental health difficulties do not focus on images of veterans with overt physical disabilities (for example, amputees).
- Ask the AFV to highlight any preferences regarding the therapist or practitioner they work with prior to, or at the point of self-referral into mental health treatment.
- Appoint an Armed Forces 'champion' within IAPT services to improve acceptability and to inform adaptations.
- Develop pathways and liaison with local specialist AFV services and the wide range of charities that can provide psycho-social support and welfare.

In addition, a number of steps that should be considered with all groups are particularly important for reducing barriers with this group:

- Emphasise expertise of therapist and treatable nature of the condition.
- Ensure flexibility in approach, considering increased tolerance of some non-attended sessions.
- Consider venues outside of mental health settings.

Considerations and adaptations to clinical practice

Adaptations to clinical practice when working with AFVs include:

- If information provided at referral indicates the person is an AFV, raise this early in the session and ask if they have served in HM Armed Forces (regular or reserve).
- Do not assume patient needs and symptoms are solely related to service in the Armed Forces.
- Providing continuity of care between therapists or practitioners is particularly important with this group.
- When treating PTSD, consider *brief* work on safety, reclaiming activities that give a sense of meaning, on anger, loss, mood regulation or sleep, before processing the trauma, if these issues are particularly prominent.
- Where necessary co-ordinate ongoing engagement with AFV organisations, groups and services.
- Identify any difficulties with substance misuse, poor sleep and stigma during assessment and address in treatment because these may be particularly relevant in this population.
- Demonstrate interest with acknowledgement that there may be issues about life in the Armed Forces which you do not understand but could be helped to understand as part of collaborative working.
- Increased priority placed on physical activity when serving may result in behavioural interventions (including physical activity promotion) having greatest acceptability.
- Armed Forces specific mental health focused groups/classes (if involvement is through informed choice) may help re-establish a sense of belonging and connectedness that can be lost when leaving the service. However, ensure the AFV is aware they are not required to talk to the group unless they wish to.

It will be important to have mechanisms in place to ensure that therapists and practitioners practicing CBT have a choice of supervision and are supported to deal with potentially harrowing accounts of trauma.

Training and resources

On-line courses are available to enhance understanding regarding the Armed Forces culture.

- www.e-lfh.org.uk/programmes/nhs-healthcare-for-the-armed-forces/
- portal.e-lfh.org.uk/
- elearning.rcgp.org.uk/

There are a growing number of videos and advisors to help enhance and understand Armed Forces culture. Accredited training options are available by searching for *Armed Forces Veteran awareness training UK* on any good search engine

- www.veteransgateway.org.uk
- www.contactarmedforces.co.uk

Op COURAGE: The Veterans Mental Health and Wellbeing Service

- Veterans: NHS mental health services - NHS (www.nhs.uk)

To view the full positive practice guide, please click here.

G.4 Working with Older People: Bite-sized Positive Practice Guide

Context and considerations

- Anxiety disorders and depression are not an inevitable part of growing old and, just like anyone else, people in later life can often benefit from psychological therapy. Indeed, in IAPT services the average outcomes for older people are even better than those for people of working age. IAPT services should take a role in promoting this message among older people, their family and health care professionals.
- Depression affects around one in five older people living in the community. Depression rates are higher in people who live in care homes and in people who are carers.
- Older people who are depressed are at increased risk of frailty, functional decline, reduced quality of life and cognitive decline.
- Generalised anxiety disorder is the most common anxiety problem in later life and most anxiety problems are not a new presentation.
- Older people with generalised anxiety disorder are more likely to present with somatic symptoms (for example, gastrointestinal symptoms, aches and pains) rather than cognitive or emotional symptoms (for example, worry or anxiety). Older people are under-represented in many IAPT services.
- Older people often do not ask for support with mental health problems but when they do, they are more likely to be prescribed medication rather than psychological therapies.
- Research shows that older people often think their problems with depression and anxiety are not severe enough to warrant help and, may mistakenly believe their problems are a 'normal' part of ageing and are therefore untreatable.
- Professionals may see mental health as secondary to physical health problems in later life. Mental health symptoms can also be hard to spot, as older people are more likely to be living with multiple physical health conditions.
- Not everyone who is older is frail, disabled or in need of care, but conditions that are more common among older people include heart disease, diabetes, COPD, stroke, dementia and Parkinson's disease. Many of these conditions are also associated with a higher risk of depression.

Reducing barriers to access

- Services should recognise and proactively challenge negative attitudes and stereotypes of ageing which suggest older people will not benefit from support.
- Promotional material should be displayed in environments relevant to older people, for example libraries, post offices and pharmacies and so on.
- Age-relevant imagery and non-clinical language should be used in promotional material to help older people recognise that IAPT is an appropriate service for them.
- Services should consider appointing older people champions who will run updates for professionals on age-friendly practices.
- Services should work closely with specialist older people's organisations to share knowledge and best practice of age-friendly services.
- Older people may need additional support to access services and flexible options such as home visits, outreach in to care homes and carer presence at appointments.

- Older people visit their GPs more frequently than other age groups. Services should work with colleagues in physical health settings to encourage the use of short screening tools to help identify depression and anxiety in older people.
- Ensure strategies and staff training are in place to overcome sensory changes in older people (for example hearing impairment or visual impairment) that may act as barriers and be proactive in compensating for mobility challenges and/or frailty, so that more older people are able to access treatment facilities.

Adaptations to clinical practice

- Staff must have access to dementia awareness training and consider actions that will allow those with dementia to engage with treatment, such as appointment reminders.
- Consider actions that allow for greater flexibility for appointments such as shorter but more frequent appointments.
- Older people may be more willing to engage in conversations about mental health when non-clinical language is used and tend to describe their own mental health using phrases such as 'feeling down', 'low', or 'out of sorts'.
- Consider providing older people with help using video or telephone services, including signposting to technical support if required. It should not be assumed that older people will not be able to adapt or be unwilling to accept care using multimedia and videoconference facilities.
- Make use of older peoples' life experience – a timeline can facilitate a discussion of how the person has overcome adversity in the past and has gained skills to equip them to manage their current challenges in the here and now.
- Selection, Optimisation with Compensation fits well with CBT and is applicable to LTC work. More information on Selection, Optimisation with Compensation can be found in the IAPT clinician's guide to CBT with older people.

Training and resources

- NHS HEE (2020), 'Older people's mental health competency framework'. Available at: www.e-lfh.org.uk/programmes/mental-health-training-resources/
- NHS Shropshire CCG (2018), 'New animation highlights benefits of IAPT talking therapies for older people'. Available at: www.shropshireccg.nhs.uk/news/time-to-talk-new-animation-highlights-benefits-of-iapt-talking-therapies-for-older-people/
- START (Strategies for Relatives) resources, which can be used to support caregivers are available here: www.ucl.ac.uk/psychiatry/research/mental-health-older-people/projects/start/start-resources
- Promoting the stories of people who have experienced and benefited from psychological support. Age UK has some resources here: www.ageuk.org.uk/discover/2020/01/iapt/.
- University of East Anglia, 'CBT with older people, free online course'. Available at: www.futurelearn.com/courses/cbt-older-people
- Laidlaw, K., Kishita, N., & Chellingsworth, M. (2016). Clinician's Guide to: CBT with older people, Department of Health.
- Chellingsworth, M., Kishtia, N., & Laidlaw, K. (2016). Clinician's Guide to: Low Intensity CBT with older people, Department of Health.

To view the full positive practice guide please click here

G.5 Working with Black, Asian and Minority Ethnic Communities: Bite-sized Positive Practice Guide

Context and considerations

- People from ethnic minority[z] communities are under-represented in IAPT services.
- Evidence suggests that some referrers are less likely to refer ethnic minority patients for psychological therapy. Some people from ethnic minority groups may also be less likely to refer themselves for therapy.
- A focus on maintaining engagement through the course of treatment is particularly important as treatment completion and good clinical outcomes for these communities are less likely, coupled with higher reports of negative experiences in therapy.
- Evidence shows that ethnic minority communities have higher rates of PTSD, depression, psychosis and most anxiety disorders than the wider population.
- Additional consideration should be given to the sometimes-complex nature of presentation and treatment needs for ethnic minority communities. This is of particular relevance for asylum seekers and refugees who may have experienced multiple losses and traumas. Some may not want to discuss the past, but can still be helped by therapy approaches that focus on improving their current situation.
- In some communities, the first line of support may be community healers, spiritual leaders and alternative health practitioners. Typically, patients do not disclose this to therapists for fear of being negatively judged or misunderstood for using these approaches. Once a relationship has been established, it is legitimate to ask about this and seek information from appropriate sources if unfamiliar with these practices.

Reducing barriers to access

- Routinely map community demographics and compare them with the profile of those using the service. Use of the audit tool to assure equity in access and outcomes. Where inequalities are highlighted, proactively engage and develop relationships with the identified community via established networks and methods.
- Local community engagement and outreach is essential to raise awareness of IAPT services and build an understanding of the support that IAPT can provide. This can be achieved by connecting with community groups, networks and organisations already working with these communities. Dedicated community outreach roles should be considered within IAPT services, along with other bespoke outreach initiatives.
- Ensure more people from ethnic minority backgrounds are involved in all aspects of service development, including clinical work and service management.
- Provide workshops in settings where the community may feel more at ease.
- Ensure that information leaflets and posters are available in community languages and that these have been coproduced with representatives from the appropriate community.
- At referral, it is important to check language preferences and preferences in terms of the gender and background of therapists.
- Online contact to manage referral and appointments may make it easier to overcome language barriers, as translation apps can be used.

[z] In this Bite-sized Positive Practice Guide, we have retained the title which refers to 'Black, Asian and minority ethnic communities'. In the rest of the summary, we have adopted the language conventions recommended by the UK government style guide by using the term 'ethnic minority', which is seen as more inclusive: www.ethnicity-facts-figures.service.gov.uk/style-guide/writing-about-ethnicity

Adaptations to clinical practice

Therapy delivery models may need to be adapted to improve access, retention rates and outcomes for ethnic minority communities.

Therapists should:

- Take the beliefs, values and cultural and spiritual perspectives of the patient into account throughout treatment.
- Consider the use of a genogram (family tree) that includes the migration histories of family members and a discussion about the degree of acculturation of different people in families, to aid a greater understanding of the patient's perspective.
- Use an appropriately trained and supported interpreter when required, checking that this is acceptable to the patient and making additional time available.
  - Where possible, use the same interpreter throughout therapy and ensure that they are adequately prepared for the session and have the opportunity for debriefing.
  - Keep questions and statements brief and clear, to aid interpretation. If it is felt that an interpreter has summarised a lengthy response in such a way that the meaning is at risk of being lost, it can be helpful to ask the interpreter to repeat their exact response to check for this.

Services should:

- Consider and develop culturally appropriate and sensitive reasonable adjustments for particular communities with members of that community. This may include adapting language, values, metaphors and techniques.
- Invest in training staff in culturally adapted and culturally responsive therapies.
- Ensure through proactive review, recruitment, training and succession planning, that the workforce reflects the diversity of the communities served at all levels and that ethnic minority staff are supported through staff networks and have equal opportunities for career progression.
- Embed the audit tool within the short positive practice guide to support with implementation of processes to drive improvements in experience, access and outcomes for people from ethnic minority communities.

Training and resources

There are a growing number of resources to enhance our work with, and understanding of, ethnic minority communities:

www.cambridge.org/core/journals/the-cognitive-behaviour-therapist/special-issues/cultural-adaptations-of-cbt
www.refugeecouncil.org.uk/
www.stonewall.org.uk/search/BAME
www.redcross.org.uk/get-help/get-help-as-a-refugee
www.gypsy-traveller.org
www.uel.ac.uk/research/refugee-mental-health-and-wellbeing-portal/resource-centre/translated-mental-health-resources

Additional guidance and training are also available via:

www.babcp.com/Training/Events.aspx
www.refugeecouncil.org.uk/training_conferences/training
www.pasaloproject.org/
roar.uel.ac.uk/3150/1/British%20Psychological%20Society%20guidelines%20working%20with%20interpreters.pdf

To view the full positive practice guide please click here

G.6 Working with Offenders in Prison: Bite-sized Positive Practice Guide

Context and considerations

- More than half the offenders in prison experience common mental health problems such as depression and anxiety.
- Post-traumatic stress disorder (PTSD) and complex trauma constitute a significant problem within prisons. Prevalence of PTSD among prisoners is considerably higher than that of the general population.
- For many offenders, prison is the first/only stable place they may have experienced.
- Offenders are unlikely to have been registered with a GP prior to commencing their sentence.
- Women are more likely to be the primary carers of children, which can make their prison experience significantly different from men. Women also tend to be located in prisons a long way from their homes because there are fewer prisons for women. This may detrimentally effect family relationships, receiving visits and resettlement in the community.
- Many women in prison have experienced domestic violence and/or sexual abuse.
- Offenders serving lengthy sentences (of 2 years or more) are likely to be more stable geographically and located in one prison for much (or all) of their sentence.
- Offenders remanded in custody or serving short prison sentences are much more challenging to engage because they are likely to move between prison, hospital and community, as well as moving between different prisons.
- Prisoners nearing release are often not informed of the location to which they will be held on licence until close to their release date, compounding their stress levels and reducing the opportunity to proactively access community support.

Reducing barriers to access

- Those offered treatment in prison are often not able to continue treatment on release into the community. Onward pathways should be developed which bridge disruption caused by prison.
- Prisons and criminal justice settings are quite literally ‘closed door environments’. To engage effectively with the experiences of offenders it may be helpful for IAPT therapists to have previous experience working within the criminal justice system or with offenders.

Adaptations to clinical practice

- It may not be possible for offenders to remain with a therapist across establishments, between prison and community or even within teams, but an offender can be provided with a sense of continuity through the style and type of care that is provided.
- The IAPT Dataset and disorder-specific measures should be delivered in an offender friendly manner.
- Interventions may require adaptation when working within the security of prisons.
- Prison regime changes may disrupt the flow of therapy.
- Appropriate therapeutic spaces may be difficult to access within prisons.

Training and resources

Therapists may need additional training and supervision when working in a prison setting. It is advisable for IAPT staff working with offenders to access the training and experience already present within Criminal Justice settings.

Please see all sections of Appendix G.7, the 'Working with Ex-Offenders in the Community: Bite-sized Positive Practice Guide' below, for additional information.

To view the full positive practice guide please click here

G.7 Working with Ex-Offenders in the Community: Bite-sized Positive Practice Guide

Context and considerations

- Offenders and ex-offenders are particularly vulnerable to mental ill health before, during and after contact with the police, courts, prison and probation services. Many within this population have experienced a lifetime of vulnerability and encounter profound and ongoing social, economic and health inequalities.
- The mental health consequences of contact with the criminal justice system can be long lasting. Ex-offenders face barriers to returning to 'normal' life. Lasting trauma from prison experience, difficulty in gaining employment due to a criminal record, and the ongoing stigma of 'being a criminal', can lead to a cycle of worsening mental health.
- Offenders tend to come from the more deprived and socially excluded sections of our communities and have significantly higher than average health care needs.
- Screening for PTSD should be considered due to the high levels of trauma in this population.
- Comorbidity with substance misuse and personality difficulties can result in exclusion from some IAPT services. It is important that services allow treatment of anxiety and depression whatever the other diagnoses, when this anxiety and/or depression can be treated appropriately by IAPT (see Positive Practice Guide for Working with People who use Drugs and Alcohol).
- Literacy problems are particularly relevant for offenders.
- The incidence of mental health disorder within the offending community is higher for women, older people and those from ethnic minority groups (see Black, Asian and Minority Ethnic Service User Positive Practice Guide and Older People Positive Practice Guide).
- Improving the mental health of offenders experiencing mild to moderate mental health difficulties represents a valuable opportunity to identify and address their wider health needs and potentially reduce re-offending rates.
- Offenders tend to access IAPT services with secondary symptoms. Depression, PTSD and anxiety may present as anger, self-harm, drug misuse, sleep issues, obsessive behaviour and self-harm.

Reducing barriers to access

- It is important for IAPT and Criminal Justice Mental Health services to work together to address the needs of offenders with common mental health disorders. Information-sharing and communication between IAPT and wider services at the local level can be a significant first step to increasing and improving access for this population.
- High levels of social exclusion can mean that some offenders do not access a GP and therefore have poorer contact with primary care, limiting their access to IAPT services. Promoting self-referral routes into IAPT services for this population could be a valuable method of removing this barrier alongside promoting referral from probation officers or court officials.
- Offenders need continuity of care between prison establishments and through the gate into the community. Effective pathways between prison and community IAPT services enable smooth transfer of care when needed.

Adaptations to clinical practice

- Engagement may be difficult. As such, services need to be flexible in approach, for example some tolerance to non-attended sessions.
- Therapeutic engagement and the development of trust may take longer with this patient group who are less likely to seek help and may minimise symptoms.
- IAPT clinicians may not believe that they have the necessary skills to deal with the needs of offenders and therefore may be reluctant to offer treatment. Reciprocal training between Criminal Justice Mental Health and IAPT services can help allay these concerns.

Training and resources

On-line courses are available to enhance understanding of offender mental health:

- Offender Health Research Unit www.ohrn.nhs.uk/
- www.dualdiagnosis.co.uk/National_e-learningHub.ink
- www.nacro.org.uk/about-us/
- www.app.college.police.uk/app-content/major-investigation-and-public-protection/managing-sexual-offenders-and-violent-offenders/offenders-with-mental-health-issues/
- www.rcslt.org/learning/the-box-training

To view the full positive practice guide please click here

G.8 Working with people who use drugs and alcohol: Bite-sized positive practice guide

Context and considerations

- Drug and alcohol misuse (current or historic) 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.
- IAPT does not provide complex interventions to treat drug and alcohol misuse. If a person is unable to attend appointments without being under the influence of drugs or alcohol, it is important to engage them with the local addiction service until appropriate stability is achieved. IAPT treatment can then start.
- Routine assessment of current use of drugs and alcohol is recommended. Where appropriate, screening tools suggested by local drug and alcohol services should be used to inform a judgement of the extent to which substance use is problematic and needs direct targeted intervention.
- Many whose use is not significantly problematic respond well to simple advice to cut down their drug and alcohol use, particularly if the reasons to do so are articulated in a coherent psychological formulation.
- People with a history of drug and alcohol problems, and receiving treatment, do not necessarily pose any different challenges for IAPT services.
- Consider current involvement with a drug and alcohol service an advantage to psychological therapy.
- Where appropriate, IAPT and substance misuse services should work together to address the needs of people with co-occurring problems.
- It is important that the patient has motivation to limit their drug or alcohol use.
- Psychological interventions within drug and alcohol services is often limited. IAPT may provide one of the only local resources to access psychological therapy for common mental health problems.
- Between 70 and 80% of patients in drug and alcohol services have common mental health problems. A significant number of IAPT patients are likely to be using drugs and/or drinking at harmful levels, contributing to their mental health problems.
- While people with serious drug and alcohol problems come from all walks of life and different backgrounds, they are often affected by multiple disadvantages, either as a consequence, or as a cause, of their substance misuse.
- Substance misuse may be particularly relevant in the armed forces veteran population (see Veterans Positive Practice Guide).

Reducing barriers to access

- Many feel shame about their drug or alcohol use. It is important to maintain a non-judgemental and proportionate attitude to information about substance use, neither minimising the extent of a problem nor over-stating its significance.
- Patients may be concerned about discussing a drug or alcohol problem because they fear information will be passed on to others, for example police, safeguarding and so on. It is therefore important to be clear and explicit about confidentiality and constraints around this.

- Reciprocal training between IAPT and the local addiction treatment service can help develop clear access, transfer, and collaborative working protocols which will, in turn, support access for this patient group.

Adaptations to clinical practice

- Engagement may be difficult. As such, services need to be flexible in approach, for example tolerance of some non-attended sessions.
- As part of treatment contracting, it is good practice to specify that patients must come sober to sessions. They should also not use while engaging in anxiety-related between-session behavioural experiments as concurrent use is likely to interfere with learning and the extinction of fear.
- Therapists should explore the patients view of the relationship between their substance use and their psychological distress. This has the potential to open a constructive dialogue and help identify any function the substance use serves.
- Use of substance use diaries can help explore the inter-dependencies, particularly when integrated with thought records.
- Clinicians may feel anxious about a lack of knowledge around illicit drugs. This need not interfere with psychological work nor be a barrier to taking on drug using patients. Suspending judgement and embracing a spirit of curiosity will enable the patient to speak openly about their experiences and foster a collaborative relationship.

Training and resources

Basic drug and alcohol awareness training to enable an understanding of the effects of substances and related health issues including impact on mental health and psychological well-being is recommended.

On-line courses are available to enhance understanding of substance use issues and treatment:

- www.dualdiagnosis.co.uk/National_e-learningHub.ink
- www.e-lfh.org.uk/programmes/all-our-health/
- elearning.rcgp.org.uk/
- neptune-clinical-guidance.co.uk/wp-content/uploads/2015/03/NEPTUNE-Guidance-March-2015.pdf
- www.alcoholics-anonymous.org.uk/
- www.adfam.org.uk/ is a national charity working with families affected by drugs and alcohol.

To view the full positive practice guide please click here

Appendix H: Helpful resources

This resource pack provides commissioners and providers with examples of positive practice and helpful resources to support IAPT service expansion, development and delivery.

Positive practice examples and models

Section H.1 (pp. 117–26) provides positive practice examples and models from IAPT services. Further details on these services can be found on the Positive Practice in Mental Health Collaborative (PPiMH) website.

Case identification tools

Section H.2 (p. 127) provides copies of case identification tools used in IAPT services.

Outcome measures

Section H.3 (pp. 128–54) provides copies of the outcome measures forms recommended for use in IAPT services and information on understanding them.

Web-based resources

Section H.4 (pp. 155–56) contains links to helpful web-based resources, including:

- National guidance
- Useful resources on IAPT background and context
- Useful resources on IAPT
- Useful resources on integrating physical and mental health services
- Useful organisations
- Other helpful resources

IAPT Futures web page

This workspace is hosted by the National IAPT programme and contains up-to-date guidance and materials relevant to the delivery of IAPT across England. The workspace is available for anyone working as part of, or alongside, an NHS funded IAPT service and provides a forum to share best practice and contact IAPT colleagues across England. If you would like access to this platform, please contact england.mentalhealth@nhs.net

H.1 Positive practice examples

There are many examples of positive practice in IAPT services. The small selection of examples from 2017 that are included here are not templates for whole-service provision. Instead, they are selected to illustrate how services have tackled one or more specific problems.

The PPiMH is a user-led, multi-agency collaborative of 75 organisations, including NHS Trusts, CCGs, third sector providers and service user groups. The aim of the organisation is to facilitate shared learning of positive practice in mental health services across organisations and sectors. The PPiMH provides a directory of positive practice in mental health services. The NCCMH workedg together with the PPiMH to identify and share examples of positive practice in mental health across England.

Map of positive practice examples for IAPT

Bath and North East Somerset

Demonstrated area(s) of positive practice

- Improving recovery:
  - data-driven reflective practice

Background

Bath and North East Somerset recommissioned their IAPT service in August 2013. After a year, the service was not meeting the national 50% recovery standard. The service experienced high levels of people dropping out of treatment, which is synonymous with poorer recovery rates.

The approach

Drawing inspiration from the way other services had improved recovery, the service used a Plan, Do, Study, Act (PDSA) approach. This enabled them to identify themes in the data affecting recovery. These included people being discharged having achieved good improvement but not meeting recovery; people not being offered the full range of NICE-recommended treatments; people not being offered a trial at Step 2 of the IAPT stepped-care approach if appropriate; staff not attending to scores from measures; and failure to repeat ADSMs. Attending to staff supervision and continuing development while instigating new procedures was of great importance.

Outcomes

Within 6 months the recovery rates had improved to more than 60%. Drop-out rates were reduced, and clients reported greater satisfaction on the PEQs. In the 2015/16 IAPT Annual Report, Bath and North East Somerset Talking Therapies Service demonstrated the highest national recovery rate overall.

iCope – Camden

Demonstrated area(s) of positive practice

- Improving equity of access and outcomes for all:
  - black, Asian and minority ethnic (BAME) communities

Background

iCope Psychological Therapies Service is integrated with primary care and offers treatment to people in over 90% of Camden GP practices. A key objective for the service was to make it more accessible to under-represented groups including older people, people from ethnic minorities and people with LTCs.

The Bangladeshi community is one of the largest minority communities and there is generally a low take-up of mental health services by its members.

The approach

iCope formed a working group, with the aim of increasing access for people from ethnic minorities. The service sought to engage ethnic minority communities by increasing knowledge of local services and removing stigma. The team worked closely with a range of organisations to ensure pathways for common mental health problems are easy to access and use. The team had iCope stalls at Bangladeshi festivals in Camden and has produced a video to be aired in GP practices across Camden. The video is in Bengali and aims to de-stigmatise mental health problems and offer religious permission to access support outside of the family.

iCope offers psychological therapy in Bengali Sylheti dialect (from one clinical psychologist and two psychological wellbeing practitioners [PWPs]). The service also provides group work (the Staying Well Group) facilitated by a PWP who can speak Bengali.

In addition, the service worked collaboratively with Camden Diabetes Integrated Practice Unit (Royal Free Hospital) to administer a 'Stress Management and Diabetes' session in Bengali as part of the DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed) Type 2 Diabetes Education Programme.

Outcomes

- Preliminary feedback from the Staying Well Group is that people found it helpful having practitioners who speak their language, and the service is carrying out interviews to inform and improve the group
- High-intensity individual therapy: client feedback is positive and reflected in improvements in outcomes.

Further information

For more information contact Cim-tr.icopecamden@nhs.net Tel: 0203 317 6670

PPiMH case study

iCope – Islington

Demonstrated area(s) of positive practice

- Improving recovery:
  - supportive professional learning

Background

In 2014, iCope Islington established a recovery working group to ensure that it met the national target of 50% of people treated in IAPT services moving to recovery. The service implemented 'recovery consultations' to address this objective.

The approach

Recovery consultations are a supportive professional learning environment, focused on developing the quality of therapy delivered by individual clinicians. Within the approach, it is acknowledged that a variety of factors can contribute to recovery rates. This enables open discussion of recovery rates, and improvement via problem solving exploration and agreement on specific learning points and targets.
The service started by inviting all Step 2 clinicians who had completed their training to have a 1-hour recovery consultation, at a time of their convenience, in a quiet and confidential space. This was then extended to include all Step 3 workers and then any remaining clinicians identified as having lower than average recovery rates were invited.

The consultations are used to discuss a clinician's individual recovery rate and to compare recovered and non-recovered cases. This in-depth discussion results in individually tailored learning points for each clinician to act upon as their recovery-focused professional development goals.

Outcomes

Recovery rates increased from 40.9% in September 2015 to an average of 51% for the 6-month period between March and September 2016.

Further information

For more information contact lcope.referrals@candi.nhs.uk

PPiMH case study

Lambeth IAPT in HMP Brixton

Demonstrated area(s) of positive practice

- Improving equity of access and outcomes for all:
  - prisoner and offender populations

Background

Lambeth IAPT has been running a service for inmates in HMP (Her Majesty's Prison) Brixton since 2009. This is a category C resettlement prison, housing approximately 800 inmates. It caters for people coming to the end of their sentences, or those serving relatively short sentences (under 2 years). The service offers CBT at high and low intensity, as well as brief integrative counselling, to treat common mental health problems. It is embedded within the healthcare department and has close links with prison GPs and the secondary care mental health team.

Compared with the general population, offenders are more likely to experience mental health problems but less likely to seek help. Therefore, prison is an opportunity for positive change and to identify and treat common mental health problems that might otherwise remain undetected.

The major challenges that the service faces include clinical issues such as: complexity of presentations; high prevalence of substance misuse; high prevalence of suicide and self-harm; and a higher prevalence of literacy problems. In addition, there are systemic

challenges, such as: frequent security lockdowns; lack of suitable spaces for therapy; mistrust and stigma around mental health problems; security taking priority over therapy; and a high drop-out rate because prisoners often get transferred.

The approach

The prison sits within the London borough of Lambeth and when Lambeth IAPT was first commissioned, the CCG were keen for prisoners to be able access therapy in the same way as residents of the borough. The care pathway in the prison mirrors that in the community: a single point of access, triage assessment and a stepped-care approach encompassing CBT and counselling.

The team consists of four CBT therapists and six counsellors. All the therapists spend the majority of their time working in the community and provide services in the prison 1–2 days a week. Having a split between community and prison work reduces the chances of therapist burnout and ensures that their core therapy skills are maintained.

Outcomes

The service obtains feedback from prisoners at the end of therapy and it has been overwhelmingly positive. The team also collects routine outcome measures (data set and ADSMs). The recovery rates for those who complete treatment are comparable with the community samples.

> "Before I had this counselling, I was really down but now I am a lot happier and find it easier to socialise and express myself and also feel a lot better in myself."
>
> **Service user**

The LGBT Foundation – Manchester

Demonstrated area(s) of positive practice

- Improving equity of access and outcomes for all:
  - LGBT people

Background

The LGBT Foundation is a third sector organisation that has been working with and supporting lesbian, gay, bisexual and transgender people over the last two decades. The foundation was commissioned to develop an IAPT service in 2015 and set out to develop an LGBT specific IAPT service, delivering therapeutic interventions concordant with NICE guidelines, IAPT requirements and meeting the needs of the communities that they support.

The approach

The provision of LGBT affirmative stepped-care interventions underpinned the development of the service and some clinical policies and procedures were adapted to better support a third sector organisation and community context. Feedback from people using the existing counselling service highlighted challenges that they had faced, such as limitations in awareness of problems experienced by LGBT people, or the use of heteronormative or gender normative language.

Depression and anxiety disorders are common issues experienced by people accessing the LGBT Foundation. The team created a delivery model that embedded Step 2 and Step 3 interventions within the existing talking therapies programme.

The dedicated IAPT service launched in July 2016, delivering Step 2 work as well as counselling for depression and interpersonal therapy interventions. The workforce includes one PWP and two IAPT counsellors delivering Step 2 and Step 3 interventions. The delivery model includes a group work component, comprising a self-esteem course, mindfulness workshops and stress management groups.

The foundation is also working in partnership with Greater Manchester and Eastern Cheshire Strategic Clinical Network to deliver training on best practice on working with lesbian, gay, bisexual and transgender people, focusing on ethnic minority individuals and faith groups.

Outcomes

The talking therapies programmes waiting list decreased considerably and by the third quarter, all clients self-referring or being referred to the service were assessed within 6 weeks from the referral date.

The scores collected from the service delivery indicate that average recovery rates are consistently higher than 50%.

"My life has changed completely during the time between my first and last sessions. Thanks to the service I have found so much confidence in myself and know that I can move on with my life and be happy in my own skin."

Service user

PPiMH case study

Positive Step – North Somerset

Demonstrated area(s) of positive practice

- Improving equity of access and outcomes for all:
  - carers

Background

Positive Step is run by Avon and Wiltshire Mental Health Partnership NHS Trust and the charity Second Step. North Somerset has a large elderly population and, consequently, a high number of carers. A dedicated programme for carers was commissioned in 2013 after research indicated that 30% of North Somerset's 20,000 carers were struggling to cope.

The approach

The carers' programme aims to support carers and build resilience. The delivery of the therapy is an important consideration within the programme as carers may not be able to attend sessions as regularly as other people. As a result, the delivery is flexible, and carers are encouraged to participate as much or as little as they can manage.

Group workshops can be taken as a course or on an ad-hoc basis and are supported with handouts, audio CDs and additional information available through regular newsletters and online. These workshops are built upon the principles of CBT and organised around specific

themes, aimed at building carers' resilience, including: managing stress; 'improving how you feel about yourself'; managing frustrations; 'keeping your spirits up'; and coping with change. Those who need intensive help receive one-to-one support by phone or face-to-face.

Carers can self-refer, or referrals can be made through a GP, primary or secondary care, or via third sector organisations.

Outcomes

That first year saw 98 referrals to the programme, with 262 in 2014/15. In 2015/16, more than 240 had been helped by mid-February and closer ties with local agencies aim to increase referral rates further.

"Positive Step gave me the strength I needed to carry on. Even just going along to the workshop for a couple of hours was refreshing. It was very emotional too. The other people were also carers, and had similar problems so we could all share. We knew with empathy where they were coming from, even if they didn't have the words."
Service user

"Positive Step is really helping to take the pressure off carers in North Somerset. Too often we hear of carers struggling to carry the burden of looking after loved ones, and yet a simple scheme such as this with relatively minor changes to how therapies are delivered can make all the difference in the world."
Tim Kendall, National Clinical Director for Mental Health, NHS England

PPiMH case study

North Tyneside Talking Therapies Service

Demonstrated area(s) of positive practice

- Reducing waiting times:
  - interim pathway

Background

The North Tyneside Talking Therapies Service inherited large waiting lists after a re-tendering process. To clear these waits the service worked with the mental health intensive support team to implement a waiting list initiative based on an interim, six-session, focused CBT model. Within this model, therapists saw 25 people per week to clear the high-intensity waiting list.

The approach

The service combined two Step 3 waiting lists. All cases were reviewed based on information given at referral, assessment and identified problem descriptors. People who presented with trauma and OCD were ruled out because it was felt that they would not benefit from a six-session therapy model. Of the 511 people waiting, 459 were identified as

appropriate for the waiting list initiative. Eight (whole-time equivalent) therapists were recruited to work on the interim pathway and therapy was supported by a 6-month subscription to an online support platform (The Big White Wall). The service developed a strict missed appointment and cancellation policy, signed by both clinician and the service user. Other therapists were then able to offer people presenting with OCD or trauma a course of treatment as necessary to achieve maximum recovery results.

Outcomes

The Step 3 waiting list reduced from 511 in January 2016 to 81 in May 2016 and length of wait was also considerably reduced.

PPiMH case study

Slough Talking Therapies

Demonstrated area(s) of positive practice

- Improving equity of access and outcomes for all:
  - People from Black, Asian and minority ethnic groups
- Improving recovery

Background

Slough Talking Therapies IAPT Service was set up in 2010. The major challenge faced by the service was to increase access in line with a diverse population. The challenges for delivery included the need for interpreters and therapists delivering treatment in other languages and consideration of the deprivation levels in the borough.

The approach

In January 2014, the service established the Slough outreach project as a quality improvement plan. The aim was to increase referrals and clients entering treatment in Slough and to foster good GP relationships.

The quality improvement project included increasing training and communication in GP surgeries and attending practice meetings. The service also:

- visited or phoned all GP surgeries to find out what was working and what could be improved
- researched Slough wards and represented communities to create a detailed community directory
- contacted faith groups, community groups and third sector organisations to increase cross-cultural collaboration
- set up a client forum to talk to people about what they wanted or needed from the service
- liaised with local libraries to launch a Talking Therapies stand
- visited the local college to discuss setting up student mental health classes
- set up an information stand in a local supermarket to promote the service
- produced a CD in different languages to inform clients about the service when they are first referred.

Since November 2015 the service has also established welcome/drop-in clinics to help clients who may struggle with accessing the service in the usual way. Clinicians will set aside 30 to 60 minutes to see drop-in clients and welcome them to the service.

Outcomes

The access to the service has improved significantly; so far in 2016 they have met the monthly access targets. In addition to the increase in access, the Slough Talking Therapies team are now consistently achieving a 50 to 52% recovery rate.

PPiMH case study

Sheffield IAPT service

Demonstrated area(s) of positive practice

- Reducing waiting times

Background

Sheffield IAPT service was launched in 2008 and is predominantly based in GP practices across Sheffield with a central self-referral team. The service embarked on a project to enhance the service in October 2015. The three key challenges were: data quality and aligning local and national data; meeting the 50% recovery standard; and ensuring the service was as productive and efficient as possible, while increasing choice and quality within their resources.

The approach

Sheffield IAPT undertook a number of changes, including:

- developing a new website and an online patient booking system
- providing IAPT prescription pads to support GPs
- developing data guidance and standard operating practices and data sessions delivered face-to-face within the service
- rolling out direct booking across GP practices
- developing ‘improving wellbeing’ sessions to offer a higher therapeutic dose of treatment at Step 2
- improving the service’s online offering, including Skype sessions available across PWP interventions, CBT and counselling.

Outcomes

Sheffield IAPT is now meeting and exceeding national standards. 89.81% of people that finished a course of treatment in October were seen within 6 weeks and 100% within 18 weeks. Of people starting treatment in October 2016, 95.44% were seen within 6 weeks. The recovery rate was 50.30%.

A key objective of Sheffield IAPT is to increase access to under-represented groups to ensure the promotion of equality and offer effective evidence-based interventions to meet the needs of diverse patient populations.

The service collaborated with the Sheffield Older Adult Community Mental Health Team (OACMHT) and the University of Sheffield in designing and evaluating a group treatment for generalised anxiety disorder for older people. This was called the Older Adults Overcoming Worry Group (OWG). The OWG research study created an opportunity to work collaboratively with the OACMHT and to contribute to the development of an evidence base for group treatments with older people. It also enabled the service to increase access and offer more treatment choice for older people presenting with symptoms of generalised anxiety disorder within Sheffield OACMHT and Sheffield IAPT.

Demonstrated area(s) of positive practice

- Improving equity of access and outcomes for all:
    - older people

The approach

The OWG meets for 2 hours weekly, over 12 weeks. The service implemented three OWGs in total.

Inclusion criteria for the group is:

- over 65 years and already in contact with mental health services
- generalised anxiety disorder as the primary problem and to have scored ≥8 on the GAD scale
- able to read, write and understand English.

Outcomes

The study and pilot of this scheme suggests that the OWG is an acceptable and feasible treatment option for older people.

Recovery rates at the end of treatment were 46% for generalised anxiety disorder, 0% for depression. At follow-up, this rose to 70% for generalised anxiety disorder and 33% for depression. There was no clinically significant deterioration in generalised anxiety disorder during the study or at follow-up. The opt-in rate (87%) was comparable with rates reported in trials of individual CBT for older people with generalised anxiety disorder. The drop-out rate (15%) was lower than previous studies of group CBT for older people with generalised anxiety disorder.

PPiMH case study

H.2 Case identification tools

Use of content reproduced in this section is protected by copyright. Please visit NHS Digital Copyright Licensing Service or contact clin.licences@nhs.net for permissions.

Generalised Anxiety Disorder Scale – 2 items (GAD-2)

GAD-2

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3

The cut-off score for a positive screening response is ≥3.

Reference: Kroenke K, Spitzer RL, Williams JB, Monahan, PO, Löwe B. Anxiety disorders in primary care: prevalence, impairment, comorbidity and detection. Annals of Internal Medicine. 2007:146;317-25.

Whooley questions to screen for depression

Please answer the following questions:

1. During the **past month**, have you often been bothered by feeling down, depressed or hopeless?

   ☐ YES ☐ NO

2. During the **past month**, have you often been bothered by little interest or pleasure in doing things?

   ☐ YES ☐ NO

A 'yes' answer to either of the two questions is considered a positive screening response.

Reference: Whooley MA, Avins AL, Miranda J, Browner WS. Case-finding instrument for depression. Two questions are as good as many. Journal of General Internal Medicine. 1997:128;439-45.

Mini Social Phobia Inventory Scale (Mini-SPIN)

The Mini-SPIN contains three items about avoidance and fear of embarrassment that are rated based on the past week. The items are rated using a 5-point scale: 0 = not at all, 1 = a little bit, 2 = somewhat, 3 = very much, 4 = extremely. The cut-off score for a positive screening response is ≥6. The items are as follows:

1. Fear of embarrassment causes me to avoid doing things or speaking to people.
2. I avoid activities in which I am the centre of attention.
3. Being embarrassed or looking stupid are among my worst fears.

Reference: Connor KM, Kobak KA, Churchill LE, Katzelnick D, Davidson JR. Mini-SPIN: a brief screening assessment for generalized social anxiety disorder. Depression and Anxiety. 2001:14;137-140.

H.3 Outcome measures

Use of content re-produced in this section is protected by copyright. Please visit NHS Digital Copyright Licensing Service or contact clin.licences@nhs.net for permissions.

Patient-reported outcome measures

Table 6 shows the patient-reported outcome measures recommended for routine use in IAPT services.

Translations of patient-reported outcome measures

NHS Digital have secured agreements with the majority of outcome measure tool owners for their measure to be translated into various languages.

Before using some of the outcome assessments and scales contained within the IAPT data set you are required by UK law to obtain permission from the NHS Digital Copyright Licensing Service.

Patient Health Questionnaire – 9 items (PHQ-9)

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
		PHQ9 total score (Data item 37 in the IAPT Data Standard)			

Reference: Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. Journal of General Internal Medicine. 2001; 16:606-13.

Generalised Anxiety Disorder scale – 7 items (GAD-7)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1 Feeling nervous, anxious or on edge	0	1	2	3
2 Not being able to stop or control worrying	0	1	2	3
3 Worrying too much about different things	0	1	2	3
4 Trouble relaxing	0	1	2	3
5 Being so restless that it is hard to sit still	0	1	2	3
6 Becoming easily annoyed or irritable	0	1	2	3
7 Feeling afraid as if something awful might happen	0	1	2	3

GAD7 total score

(Data item 38 in the IAPT Data Standard)

Reference: Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Archives of Internal Medicine. 2006; 166:1092-7.

Work and Social Adjustment Scale (WSAS)

Work and Social Adjustment Scale (WSA)

For each activity below, rate on its scale how much your problem impairs your ability to carry it out:

1) **work –** if you are retired or choose not to have a job for reasons unrelated to your problem, please tick here ... ☐

0	1	2	3	4	5	6	7	8
not at all		*slightly*		*definitely*		*markedly*		*very severely* *I cannot work*

2) **home management –** cleaning, tidying, shopping, cooking, looking after home/children, paying bills etc

0	1	2	3	4	5	6	7	8
not at all		*slightly*		*definitely*		*markedly*		*very severely*

3) **social leisure activities –** with other people, e.g. parties, pubs, outings, entertaining etc

0	1	2	3	4	5	6	7	8
not at all		*slightly*		*definitely*		*markedly*		*very severely*

4) **private leisure activities –** done alone, e.g. reading, gardening, sewing, hobbies, walking etc

0	1	2	3	4	5	6	7	8
not at all		*slightly*		*definitely*		*markedly*		*very severely*

5) **family and relationships –** form and maintain close relationships with others including people I live with

0	1	2	3	4	5	6	7	8
not at all		*slightly*		*definitely*		*markedly*		*very severely*

Social Phobia Inventory (SPIN)

SOCIAL PHOBIA INVENTORY (SPIN) ©

Please indicate how much the following problems have bothered you during the past week. Mark only one box for each problem, and be sure to answer all items.

		Not at all	A little bit	Somewhat	Very much	Extremely
1.	I am afraid of people in authority	☐	☐	☐	☐	☐
2.	I am bothered by blushing in front of people	☐	☐	☐	☐	☐
3.	Parties and social events scare me	☐	☐	☐	☐	☐
4.	I avoid talking to people I don't know	☐	☐	☐	☐	☐
5.	Being criticized scares me a lot	☐	☐	☐	☐	☐
6.	Fear of embarrassment causes me to avoid doing things or speaking to people	☐	☐	☐	☐	☐
7.	Sweating in front of people causes me distress	☐	☐	☐	☐	☐
8.	I avoid going to parties	☐	☐	☐	☐	☐
9.	I avoid activities in which I am the center of attention	☐	☐	☐	☐	☐
10.	Talking to strangers scares me	☐	☐	☐	☐	☐
11.	I avoid having to give speeches	☐	☐	☐	☐	☐
12.	I would do anything to avoid being criticized	☐	☐	☐	☐	☐
13.	Heart palpitations bother me when I am around people	☐	☐	☐	☐	☐
14.	I am afraid of doing things when people might be watching	☐	☐	☐	☐	☐
15.	Being embarrassed or looking stupid is among my worst fears	☐	☐	☐	☐	☐
16.	I avoid speaking to anyone in authority	☐	☐	☐	☐	☐
17.	Trembling or shaking in front of others is distressing to me	☐	☐	☐	☐	☐

Copyright ©, Jonathan Davidson. 1995, 2019. All rights reserved. The SPIN may not be reproduced or transmitted in any form, or by any means, electronic or mechanical, or by any information storage or retrieval system without permission in writing from the copyright holder at mail@cd-risc.com.

Reference: Connor KM, Davidson JRT, Churchill LE, Sherwood A, Foa EB, Weisler RH. Psychometric properties of the Social Phobia Inventory (SPIN): a new self-rating scale. British Journal of Psychiatry. 2000; 176:379–386.

Mobility Inventory (MI)

MOBILITY INVENTORY FOR AGORAPHOBIA

---

1. Please indicate the degree to which you avoid the following places or situations because of discomfort or anxiety. Rate your amount of avoidance when you are with a trusted companion and when you are alone. Do this by using the following scale:

1	2	3	4	5
never avoid	rarely avoid	avoid about half of the time	avoid most of the time	always avoid

Circle the number for each situation or place under both conditions: when accompanied and when alone. Leave blank situations that do not apply to you.

Places	When accompanied					When alone				
Theaters.....................	1	2	3	4	5	1	2	3	4	5
Supermarkets...............	1	2	3	4	5	1	2	3	4	5
Shopping malls.............	1	2	3	4	5	1	2	3	4	5
Classrooms..................	1	2	3	4	5	1	2	3	4	5
Department stores..........	1	2	3	4	5	1	2	3	4	5
Restaurants..................	1	2	3	4	5	1	2	3	4	5
Museums.....................	1	2	3	4	5	1	2	3	4	5
Elevators.....................	1	2	3	4	5	1	2	3	4	5
Auditoriums/stadiums.....	1	2	3	4	5	1	2	3	4	5
Garages.......................	1	2	3	4	5	1	2	3	4	5
High places..................	1	2	3	4	5	1	2	3	4	5
Please tell how high										
Enclosed spaces............	1	2	3	4	5	1	2	3	4	5

Open Spaces	When accompanied					When alone				
Outside (for example: fields, wide streets, courtyards)..................	1	2	3	4	5	1	2	3	4	5
Inside (for example: large rooms, lobbies).............	1	2	3	4	5	1	2	3	4	5

Riding in	When accompanied					When alone				
Buses..........................	1	2	3	4	5	1	2	3	4	5
Trains..........................	1	2	3	4	5	1	2	3	4	5
Subways......................	1	2	3	4	5	1	2	3	4	5
Airplanes.....................	1	2	3	4	5	1	2	3	4	5
Boats..........................	1	2	3	4	5	1	2	3	4	5

Driving or riding in a car	When accompanied					When alone				
At anytime..................	1	2	3	4	5	1	2	3	4	5
On expressways.............	1	2	3	4	5	1	2	3	4	5

Situations	When accompanied					When alone				
Standing in lines...............	1	2	3	4	5	1	2	3	4	5

Copyright 1984, Dianne L. Chambless

Crossing bridges……………	1	2	3	4	5	1	2	3	4	5
Parties or social gatherings...	1	2	3	4	5	1	2	3	4	5
Walking on the street ……	1	2	3	4	5	1	2	3	4	5
Staying home alone………						1	2	3	4	5
Being far away from home…	1	2	3	4	5	1	2	3	4	5
Other (specify):	1	2	3	4	5	1	2	3	4	5

2. After completing the first step, circle the 5 items with which you are most concerned. Of the items listed, these are the five situations or places where avoidance/anxiety most affects your life in a negative way.

Panic attacks

3. We define a panic attack as:
   1. A high level of anxiety accompanied by….
   2. strong body reactions (heart palpitations, sweating, muscle tremors, dizziness, nausea) with….
   3. the temporary loss of the ability to plan, think, or reason and….
   4. the intense desire to escape or flee the situation (Note: this is different from high anxiety or fear alone).

Please indicate the number of panic attacks you have had in the past 7 days: ___________

How severe or intense have the panic attacks been?

1	2	3	4	5
very mild	mild	moderately severe	very severe	extremely severe

4. Many people are able to travel alone freely in the area (usually around their home) called their safety zone. Do you have such a zone? If yes, please describe:

a. its location

b. its size (e.g., radius from home)

Copyright 1984, Dianne L. Chambless

Reference: Chambless DL, Caputo GC, Jasin SE, Gracely EJ, Williams C. The Mobility Inventory for Agoraphobia. Behavior Research and Therapy 1985; 23:35-44

Obsessive-Compulsive Inventory (OCI)

OCI

Name.. Date....................

The following statements refer to experiences which many people have in their everyday lives. In the column labelled DISTRESS, please **CIRCLE** the number that best describes **HOW MUCH** that experience has **DISTRESSED** or **BOTHERED YOU DURING THE PAST MONTH**. The numbers in this column refer to the following labels: 0 = Not at all 1 = A little 2 = Moderately 3 = A lot 4 = Extremely

		DISTRESS				
1.	Unpleasant thoughts come into my mind against my will and I cannot get rid of them	0	1	2	3	4
2.	I think contact with bodily secretions (perspiration, saliva, blood, urine, etc) may contaminate my clothes or somehow harm me.	0	1	2	3	4
3.	I ask people to repeat things to me several times, even though I understood them the first time.	0	1	2	3	4
4.	I wash and clean obsessively.	0	1	2	3	4
5.	I have to review mentally past events, conversations and actions to make sure that I didn't do something wrong.	0	1	2	3	4
6.	I have saved up so many things that they get in the way.	0	1	2	3	4
7.	I check things more often than necessary	0	1	2	3	4
8.	I avoid using public toilets because I am afraid of disease or contamination.	0	1	2	3	4
9.	I repeatedly check doors, windows, drawers etc.	0	1	2	3	4
10.	I repeatedly check gas and water taps and light switches after turning them off.	0	1	2	3	4
11.	I collect things I don't need.	0	1	2	3	4
12.	I have thoughts of having hurt someone without knowing it.	0	1	2	3	4
13.	I have thoughts that I might want to harm myself or others.	0	1	2	3	4
14.	I get upset if objects are not arranged properly.	0	1	2	3	4
15.	I feel obliged to follow a particular order in dressing, undressing and washing myself.	0	1	2	3	4
16.	I feel compelled to count while I am doing things	0	1	2	3	4
17.	I am afraid of impulsively doing embarrassing or harmful things.	0	1	2	3	4
18.	I need to pray to cancel bad thoughts or feelings.	0	1	2	3	4
19.	I keep on checking forms or other things I have written.	0	1	2	3	4
20.	I get upset at the sight of knives, scissors and other sharp objects in case I lose control with them.	0	1	2	3	4
21.	I am excessively concerned about cleanliness.	0	1	2	3	4
22.	I find it difficult to touch an object when I know it has been touched by strangers or certain people.	0	1	2	3	4
23.	I need things to be arranged in a particular order	0	1	2	3	4

		DISTRESS				
24.	I get behind in my work because I repeat things over and over again.	0	1	2	3	4
25.	I feel I have to repeat certain numbers.	0	1	2	3	4
26.	After doing something carefully, I still have the impression I have not finished it.	0	1	2	3	4
27.	I find it difficult to touch garbage or dirty things.	0	1	2	3	4
28.	I find it difficult to control my own thoughts.	0	1	2	3	4
29.	I have to do things over and over again until it feels right.	0	1	2	3	4
30.	I am upset by unpleasant thoughts that come into my mind against my will.	0	1	2	3	4
31.	Before going to sleep I have to do certain things in a certain way.	0	1	2	3	4
32.	I go back to places to make sure that I have not harmed anyone.	0	1	2	3	4
33.	I frequently get nasty thoughts and have difficulty in getting rid of them.	0	1	2	3	4
34.	I avoid throwing things away because I am afraid I might need them later.	0	1	2	3	4
35.	I get upset if others change the way I have arranged my things.	0	1	2	3	4
36.	I feel that I must repeat certain words or phrases in my mind in order to wipe out bad thoughts, feelings or actions.	0	1	2	3	4
37.	After I have done things, I have persistent doubts about whether I really did them.	0	1	2	3	4
38.	I sometimes have to wash or clean myself simply because I feel contaminated.	0	1	2	3	4
39.	I feel that there are good and bad numbers.	0	1	2	3	4
40.	I repeatedly check anything which might cause a fire.	0	1	2	3	4
41.	Even when I do something very carefully I feel that it is not quite right.	0	1	2	3	4
42.	I wash my hands more often or longer than necessary.	0	1	2	3	4

OCI Scoring

For therapist use:

Washing	
Checking	
Doubting	
Ordering	
Obsessions	
Hoarding	
Neutralising	
Total	

Reference: Foa EB, Kozak MJ, Salkovskis PM, Coles ME, Amir N. The validation of a new obsessive-compulsive disorder scale: The Obsessive-Compulsive Inventory. Psychological Assessment. 1998; 10:206-214

Panic Disorder Severity Scale (PDSS)

Name:____ Date:____________________

Panic Disorder Severity Scale – Self Report Form

Several of the following questions refer to panic attacks and limited symptom attacks. For this questionnaire we define a panic attack as a sudden rush of fear or discomfort accompanied by at least 4 of the symptoms listed below. In order to qualify as a sudden rush, the symptoms must peak within 10 minutes. Episodes like panic attacks but having fewer than 4 of the listed symptoms are called limited symptom attacks. Here are the symptoms to count:

- Rapid or pounding heartbeat
- Sweating
- Trembling or shaking
- Breathlessness
- Feeling of choking
- Chest pain or discomfort
- Nausea
- Dizziness or faintness
- Feelings of unreality
- Numbness or tingling
- Chills or hot flushes
- Fear of losing control or going crazy
- Fear of dying

---

1. How many panic and limited symptoms attacks did you have during the week?

   0 No panic or limited symptom episodes
   1 Mild: no full panic attacks and no more than 1 limited symptom attack/day
   2 Moderate: 1 or 2 full panic attacks and/or multiple limited symptom attacks/day
   3 Severe: more than 2 full attacks but not more than 1/day on average
   4 Extreme: full panic attacks occurred more than once a day, more days than not

2. If you had any panic attacks during the past week, how distressing (uncomfortable, frightening) were they while they were happening? (If you had more than one, give an average rating. If you didn't have any panic attacks but did have limited symptom attacks, answer for the limited symptom attacks.)

   0 Not at all distressing, or no panic or limited symptom attacks during the past week
   1 Mildly distressing (not too intense)
   2 Moderately distressing (intense, but still manageable)
   3 Severely distressing (very intense)
   4 Extremely distressing (extreme distress during all attacks)

3. During the past week, how much have you worried or felt anxious about when your next panic attack would occur or about fears related to the attacks (for example, that they could mean you have physical or mental health problems or could cause you social embarrassment)?

   0 Not at all
   1 Occasionally or only mildly
   2 Frequently or moderately
   3 Very often or to a very disturbing degree
   4 Nearly constantly and to a disabling extent

4. During the past week were there any places or situations (e.g., public transportation, movie theaters, crowds, bridges, tunnels, shopping malls, being alone) you avoided, or felt afraid of (uncomfortable in, wanted to avoid or leave), because of fear of having a panic attack? Are there any other situations that you would have avoided or been afraid of if they had come up during the week, for the same reason? If yes to either question, please rate your level of fear and avoidance this past week.

   0 None: no fear or avoidance
   1 Mild: occasional fear and/or avoidance but I could usually confront or endure the situation. There was little or no modification of my lifestyle due to this.
   2 Moderate: noticeable fear and/or avoidance but still manageable. I avoided some situations, but I could confront them with a companion. There was some modification of my lifestyle because of this, but my overall functioning was not impaired.
   3 Severe: extensive avoidance. Substantial modification of my lifestyle was required to accommodate the avoidance making it difficult to manage usual activities.
   4 Extreme: pervasive disabling fear and/or avoidance. Extensive modification in my lifestyle was required such that important tasks were not performed.

5. During the past week, were there any activities (e.g., physical exertion, sexual relations, taking a hot shower or bath, drinking coffee, watching an exciting or scary movie) that you avoided, or felt afraid of (uncomfortable doing, wanted to avoid or stop), because they caused physical sensations like those you feel during panic attacks or that you were afraid might trigger a panic attack? Are there any other activities that you would have avoided or been afraid of if they had come up during the week for that reason? If yes to either question, please rate your level of fear and avoidance of those activities this past week.

   0 No fear or avoidance of situations or activities because of distressing physical sensations
   1 Mild: occasional fear and/or avoidance, but usually I could confront or endure with little distress activities that cause physical sensations. There was little modification of my lifestyle due to this.
   2 Moderate: noticeable avoidance but still manageable. There was definite, but limited, modification of my lifestyle such that my overall functioning was not impaired.
   3 Severe: extensive avoidance. There was substantial modification of my lifestyle or interference in my functioning.
   4 Extreme: pervasive and disabling avoidance. There was extensive modification in my lifestyle due to this such that important tasks or activities were not performed.

6. During the past week, how much did the above symptoms altogether (panic and limited symptom attacks, worry about attacks, and fear of situations and activities because of attacks) interfere with your ability to work or carry out your responsibilities at home? (If your work or home responsibilities were less than usual this past week, answer how you think you would have done if the responsibilities had been usual.)

   0 No interference with work or home responsibilities
   1 Slight interference with work or home responsibilities, but I could do nearly everything I could if I didn't have these problems.
   2 Significant interference with work or home responsibilities, but I still could manage to do the things I needed to do.
   3 Substantial impairment in work or home responsibilities; there were many important things I couldn't do because of these problems.
   4 Extreme, incapacitating impairment such that I was essentially unable to manage any work or home responsibilities.

7. During the past week, how much did panic and limited symptom attacks, worry about attacks and fear of situations and activities because of attacks interfere with your social life? (If you didn't have many opportunities to socialize this past week, answer how you think you would have done if you did have opportunities.)

   0 No interference
   1 Slight interference with social activities, but I could do nearly everything I could if I didn't have these problems.
   2 Significant interference with social activities but I could manage to do most things if I made the effort.
   3 Substantial impairment in social activities; there are many social things I couldn't do because of these problems.
   4 Extreme, incapacitating impairment, such that there was hardly anything social I could do.

Scoring the Panic Disorder Severity Scale

In scoring the Panic Disorder Severity Scale, items are rated on a scale of 0 to 4. A composite score is established by averaging the scores of the seven items. The table below can be used to convert raw scores (sum of individual item scores) into composite scores.

Raw Score	Composite Score	Raw Score	Composite Score	Raw Score	Composite Score	Raw Score	Composite Score
0	0	7	1.00	14	2.00	21	3.00
1	.14	8	1.14	15	2.14	22	3.14
2	.28	9	1.28	16	2.28	23	3.28
3	.42	10	1.42	17	2.42	24	3.42
4	.57	11	1.57	18	2.57	25	3.57
5	.71	12	1.71	19	2.71	26	3.71
6	.85	13	1.85	20	2.85	27	3.85
						28	4.00

Copyright notice: The Panic Disorder Severity Scale – Self Report Form is copyrighted by M. Katherine Shear, M.D. Permission has been granted to reproduce the scale on this website for clinicians to use in their practice and for researchers to use in non-industry studies. For other uses of the scale, the owner of the copyright should be contacted.

Citation: Shear MK, Brown TA, Barlow DH, Money R, Sholomskas DE, Woods SW, Gorman JM, Papp LA. Multicenter collaborative Panic Disorder Severity Scale. American Journal of Psychiatry 1997;154:1571-1575

PTSD Checklist for DSM-5 (PCL-5)

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 (11 April 2018) National Center for PTSD Page 1 of 1

Body Image Questionnaire Weekly

Please answer the following for how you have felt about your appearance over the past week.

1) How often do you do you **deliberately** check your feature(s)? **Not accidentally catch sight of it.** Please include looking at your feature in a mirror or other reflective surfaces like a shop window or looking at it directly or feeling it with your fingers.

0	1	2	3	4	5	6	7	8
About 40 times or more a day		About 20 times a day		About 10 times a day		About 5 times a day		Never Check

2) To what extent do you feel your feature(s) are **currently** ugly, unattractive or 'not right'?

0	1	2	3	4	5	6	7	8
Very ugly or 'not right'		Markedly unattractive		Moderately unattractive		Slightly unattractive		Not at all unattractive

3) To what extent does your feature(s) **currently** cause you a lot of distress?

0	1	2	3	4	5	6	7	8
Not at all distressing		Slightly distressing		Moderately distressing		Markedly distressing		Extremely distressing

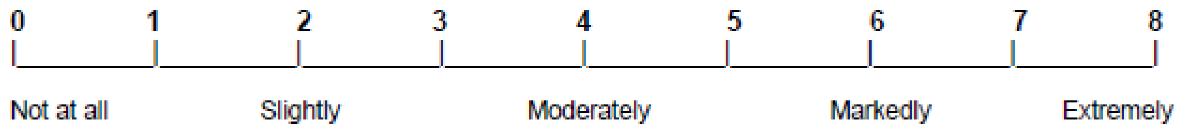
4) How often does your feature(s) **currently** lead you to avoid situations or activities?

0	1	2	3	4	5	6	7	8
Always avoid		Avoid about three quarters of the time		Avoid about half of the time		Avoid about a quarter of the time		Never avoid

5) To what extent does your feature(s) **currently** preoccupy you? That is, you think about it a lot and it is hard to stop thinking about it?

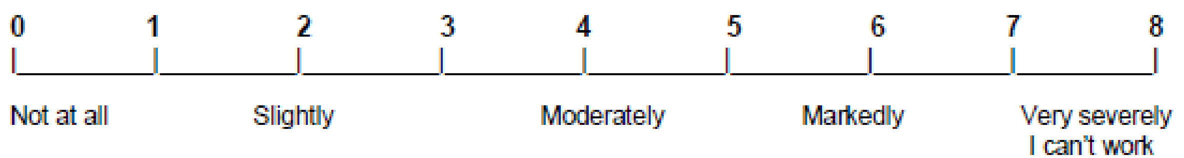
0	1	2	3	4	5	6	7	8
Not at all preoccupied		Slightly preoccupied		Moderately preoccupied		Very preoccupied		Extremely preoccupied

6) If you have a partner, to what extent does your feature(s) **currently** have an effect on your relationship with an existing partner? (e.g. affectionate feelings, number of arguments, enjoying activities together). If you do **not** have a partner, to what extent does your feature(s) **currently** have an effect on dating or developing a relationship?

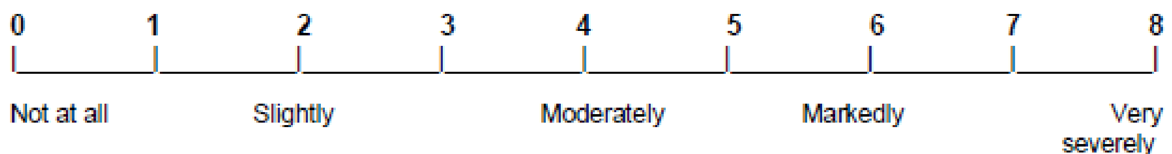


Not at all | Slightly | Moderately | Markedly | Extremely

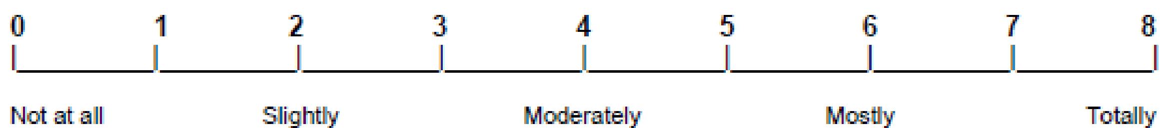
7) To what extent does your feature(s) currently interfere with your ability to work or study, or your role as a homemaker? (Please rate this even if you are not working or studying: we are interested in your ability to work or study.)



8) To what extent does your feature(s) currently interfere with your social life? (with other people, e.g. parties, pubs, clubs, outings, visits, home entertainment)



9) To what extent, do you feel your appearance is the most important aspect of who you are?



Veale, D. et al (2012).

Patient Health Questionnaire (Physical symptoms, PHQ-15)

PHYSICAL SYMPTOMS (PHQ-15)

During the past 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered at all (0)	Bothered a little (1)	Bothered a lot (2)
a. Stomach pain	☐	☐	☐
b. Back pain	☐	☐	☐
c. Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
d. Menstrual cramps or other problems with your periods ***WOMEN ONLY***	☐	☐	☐
e. Headaches	☐	☐	☐
f. Chest pain	☐	☐	☐
g. Dizziness	☐	☐	☐
h. Fainting spells	☐	☐	☐
i. Feeling your heart pound or race	☐	☐	☐
j. Shortness of breath	☐	☐	☐
k. Pain or problems during sexual intercourse	☐	☐	☐
l. Constipation, loose bowels, or diarrhea	☐	☐	☐
m. Nausea, gas, or indigestion	☐	☐	☐
n. Feeling tired or having low energy	☐	☐	☐
o. Trouble sleeping	☐	☐	☐

(For office coding: Total Score T_____ = _____ + _____)

Reference: Kroenke, K., Spitzer, R. L., & Williams, J. B. (2002). The PHQ-15: validity of a new measure for evaluating the severity of somatic symptoms. *Psychosomatic medicine*, *64*(2), 258-266.

Francis Irritable Bowel Scale

IBS-SSS – English

1a. Do you currently (in the past 10 days) suffer from abdominal (stomach) pain?

- ⓪ No → ***Skip to question 3a***
- ① Yes

1b. How severe was your abdominal (stomach) pain in the past 10 days? (Please indicate a number from 0 to 100, with 0 meaning "no pain" and 100 meaning "very severe pain")

- ❍ 0 -- No pain
- ❍ 10
- ❍ 20
- ❍ 30
- ❍ 40
- ❍ 50
- ❍ 60
- ❍ 70
- ❍ 80
- ❍ 90
- ❍ 100 -- Very severe pain

2. Please enter the number of days you had the abdominal pain in the past 10 days. (For example, if you enter 4 it means that you had pain 4 out of 10 days. If you have pain every day, enter 10.)

- ❍ 0 days
- ❍ 1
- ❍ 2
- ❍ 3
- ❍ 4
- ❍ 5
- ❍ 6
- ❍ 7
- ❍ 8
- ❍ 9
- ❍ 10 days

3a. Do you currently (in the past 10 days) suffer from abdominal distention (bloating, swollen or tight stomach)?

Women: Please ignore distention related to your period when answering this question.

- ⓪ No → ***Skip to question 4***
- ① Yes

RF012319
Copyright 1997 © by Rome Foundation. All Rights Reserved

3b. How severe was your abdominal distention/tightness in the past 10 days? (Please indicate a number from 0 to 100, with 0 meaning "no distention" and 100 meaning "very severe distention")

- ❍ 0 -- No distention
- ❍ 10
- ❍ 20
- ❍ 30
- ❍ 40
- ❍ 50
- ❍ 60
- ❍ 70
- ❍ 80
- ❍ 90
- ❍ 100 -- Very severe distention

4. How dissatisfied are you with your bowel functioning in the past 10 days? (Please indicate a number from 0 to 100, with 0 meaning "Not dissatisfied" and 100 meaning "very dissatisfied")

- ❍ 0 -- Not dissatisfied
- ❍ 10
- ❍ 20
- ❍ 30
- ❍ 40
- ❍ 50
- ❍ 60
- ❍ 70
- ❍ 80
- ❍ 90
- ❍ 100 -- Very dissatisfied

RF012319
Copyright 1997 © by Rome Foundation. All Rights Reserved

5. How much did abdominal pain or discomfort or altered bowel functioning affect or interfere with your life in general in the past 10 days? (Please indicate a number from 0 to 100, with 0 meaning “Not at all” and 100 meaning “completely”)

- ❍ 0 -- Not at all
- ❍ 10
- ❍ 20
- ❍ 30
- ❍ 40
- ❍ 50
- ❍ 60
- ❍ 70
- ❍ 80
- ❍ 90
- ❍ 100 -- Completely

Health Anxiety Inventory

SHORT WEEK

Ass / Wk / Sess: ________

HAI

Each question is this section consists of a group of four statements. Please read each group of statements carefully and then select the one which best describes your feelings, OVER THE PAST WEEK. Identify the statement by ringing the letter next to it ie. if you think that statement (a) is correct, ring statement (a); it may be that more than one statement applies, in which case, please ring any that are applicable.

1. a. I do not worry about my health.
   b. I occasionally worry about my health.
   c. I spend much of my time worrying about my health.
   d. I spend most of my time worrying about my health.

2. a. I notice aches/pains less than most other people (of my age).
   b. I notice aches/pains as much as most other people (of my age).
   c. I notice aches/pains more than most other people (of my age).
   d. I am aware of aches/pains in my body all the time.

3. a. As a rule I am not aware of bodily sensations or changes.
   b. Sometimes I am aware of bodily sensations or changes.
   c. I am often aware of bodily sensations or changes.
   d. I am constantly aware of bodily sensations or changes.

4. a. Resisting thoughts of illness is never a problem.
   b. Most of the time I can resist thoughts of illness.
   c. I try to resist thoughts of illness but am often unable to do so.
   d. Thoughts of illness are so strong that I no longer even try to resist them.

5. a. As a rule I am not afraid that I have a serious illness.
   b. I am sometimes afraid that I have a serious illness.
   c. I am often afraid that I have a serious illness.
   d. I am always afraid that I have a serious illness.

6. a. I do not have images (mental pictures) of myself being ill.
   b. I occasionally have images of myself being ill.
   c. I frequently have images of myself being ill.
   d. I constantly have images of myself being ill.

7. a. I do not have any difficulty taking my mind off thoughts about my health.
   b. I sometimes have difficulty taking my mind off thoughts about my health.
   c. I often have difficulty in taking my mind off thoughts about my health.
   d. Nothing can take my mind off thoughts about my health.

8. a. I am lastingly relieved if my doctor tells me there is nothing wrong.
   b. I am initially relieved but the worries sometimes return later.
   c. I am initially relieved but the worries always return later.
   d. I am not relieved if my doctor tells me there is nothing wrong.

9. a. If I hear about an illness I never think I have it myself.
   b. If I hear about an illness I sometimes think I have it myself.
   c. If I hear about an illness I often think I have it myself.
   d. If I hear about an illness I always think I have it myself.

10. a. If I have a bodily sensation or change I rarely wonder what it means.
    b. If I have a bodily sensation or change I often wonder what it means.
    c. If I have a bodily sensation or change I always wonder what it means.
    d. If I have a bodily sensation or change I must know what it means.

11. a. I usually feel at very low risk of developing a serious illness.
    b. I usually feel at fairly low risk of developing a serious illness.
    c. I usually feel at moderate risk of developing a serious illness.
    d. I usually feel at high risk of developing a serious illness.

12. a. I never think I have a serious illness.
    b. I sometimes think I have a serious illness.
    c. I often think I have a serious illness.
    d. I usually think that I am seriously ill.

13. a. If I notice an unexplained bodily sensation I don't find it difficult to think about other things.
    b. If I notice an unexplained bodily sensation I sometimes find it difficult to think about other things.
    c. If I notice an unexplained bodily sensation I often find it difficult to think about other things.
    d. If I notice an unexplained bodily sensation I always find it difficult to think about other things.

14. a. My family/friends would say I do not worry enough about my health.
    b. My family/friends would say I have a normal attitude to my health.
    c. My family/friends would say I worry too much about my health.
    d. My family/friends would say I am a hypochondriac.

For the following questions, please think about what it might be like if you had a serious illness of a type which particularly concerns you (such as heart disease, cancer, multiple sclerosis and so on). Obviously you cannot know for definite what it would be like; please give your best estimate of what you think might happen, basing your estimate on what you know about yourself and serious illness in general.

15. a. If I had a serious illness I would still be able to enjoy things in my life quite a lot.
    b. If I had a serious illness I would still be able to enjoy things in my life a little.
    c. If I had a serious illness I would be almost completely unable to enjoy things in my life.
    d. If I had a serious illness I would be completely unable to enjoy life at all.

16. a. If I developed a serious illness there is a good chance that modern medicine would be able to cure me.
    b. If I developed a serious illness there is a moderate chance that modern medicine would be able to cure me.
    c. If I developed a serious illness there is a very small chance that modern medicine would be able to cure me.
    d. If I developed a serious illness there is no chance that modern medicine would be able to cure me.

17. a. A serious illness would ruin some aspects of my life.
    b. A serious illness would ruin many aspects of my life.
    c. A serious illness would ruin almost every aspect of my life.
    d. A serious illness would ruin every aspect of my life.

18. a. If I had a serious illness I would not feel that I had lost my dignity.
    b. If I had a serious illness I would feel that I had lost a little of my dignity.
    c. If I had a serious illness I would feel that I had lost quite a lot of my dignity.
    d. If I had a serious illness I would feel that I had totally lost my dignity.

Choose a number from the scale below to show how much you would avoid each of the situations listed below because of fear or other unpleasant feelings. Then write the number you chose in the space provided.

0...........1...........2...........3...........4...........5...........6...........7..........8

Would not avoid it	Slightly avoid it	Definitely avoid it	Markedly avoid it	Always avoid it

1. Consulting your family doctor..........................._______
2. Visiting a friend in hospital..............................._______
3. Visiting a relative in hospital............................_______
4. Going to a hospital for treatment....................._______
5. Talking about illness.._______
6. Reading about illness......................................_______
7. Visiting a hospital for other reasons (e.g. delivering a message)..........................._______
8. Watching TV programmes about illness.........._______
9. Listening to radio programmes about illness....._______
10. Thinking about illness....................................._______

Choose a number from the scale below which best describes how often you seek reassurance about your health, from each of the sources described below. Then write the number you have chosen in the space provided.

0...........1...........2...........3...........4...........5...........6...........7..........8

Never	Rarely	Sometimes	Often	Daily

1. Friends.._______
2. Family.._______
3. Reading books.._______
4. Checking body for changes.............................._______
5. Family doctor.._______
6. Nurses.._______
7. Hospital outpatient clinic.................................._______
8. Hospital casualty.._______
9. Other (specify)..._______

Chalder Fatigue Questionnaire (CFQ)

chalder fatigue scale

name: ______________________________ date: _______

We would like to know more about any problems you have had with feeling tired, weak or lacking in energy in the last month. Please answer ALL the questions by ticking the answer which applies to you most closely. If you have been feeling tired for a long while, then compare yourself to how you felt when you were last well. Please tick only one box per line.

	less than usual	***no more than usual***	***more than usual***	***much more than usual***
do you have problems with tiredness?				
do you need to rest more?				
do you feel sleepy or drowsy?				
do you have problems starting things?				
do you lack energy?				
do you have less strength in your muscles?				
do you feel weak?				
do you have difficulties concentrating?				
do you make slips of the tongue when speaking?				
do you find it more difficult to find the right word?				
	better than usual	***no worse than usual***	***worse than usual***	***much worse than usual***
how is your memory?				

This scale can be scored "bimodally" with columns representing 0, 0, 1 & 1 and a range from 0 to 11 with a total of 4 or more qualifying for "caseness". Alternatively it can be scored in "Likert" style 0, 1, 2 & 3 with a range from 0 to 33. Mean "bimodal" score for CFS sufferers was 9.14 (SD 2.73) and for a community sample 3.27 (SD 3.21). Mean "Likert" score was 24.4 (SD 5.8) and 14.2 (SD 4.6).

total (0-33) =

Cella, M. and T. Chalder (2010). *"Measuring fatigue in clinical and community settings."* J Psychosom Res 69(1): 17-22. This study involved 361 CFS sufferers and 1615 individuals from the community. Average age was in the 30's. Fatigue levels were similar for males and females. A score of 29 discriminated between CFS sufferers and the community sample in 96% of cases and a score in the 30's discriminated in 100% of cases. The CFS sufferers also scored a mean of 26.99 on the Work & Social Adjustment Scale (W&SAS) with a SD of 8.6 (i.e. about 70% scoring between 18.4 and 35.6).

Patient-reported experience measures

The assessment PEQ

Assessment PEQ - version 3
(updated for IAPT data set v2)

Please help us improve our service by answering some questions about the service you have so far received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions.

Please tick one box for each question

	CHOICE	YES	NO	N/A
1	Were you given information about options for choosing a treatment that is appropriate for your problems?	☐	☐	
2	Do you prefer any of the treatments among the options available?	☐	☐	
3	Have you been offered your preference?	☐	☐	☐
4	Did your assessment cover your employment needs?	☐	☐	☐

	SATISFACTION	Completely Satisfied	Mostly Satisfied	Neither Satisfied nor Dis-satisfied	Not Satisfied	Not at all Satisfied
1	How satisfied were you with your assessment?	☐	☐	☐	☐	☐

Please use this space to tell us about your experience of our service so far

First Name……………………………….
Surname…………………………………
Date of Birth……………………………..

The treatment PEQ

Note: Version 3 of the Treatment PEQ includes a 'not applicable' option for question 6. This has been added to the Technical Output Specification for v2.1 of the IAPT dataset and will collected from its commencement.

Treatment PEQ - version 3
(updated for IAPT data set v2)

Please help us improve our service by answering some questions about the service you have so far received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions.

Please tick one box for each question

		At all Times	Most of the Time	Sometimes	Rarely	Never	N/A
1	Did staff listen to you and treat your concerns seriously?	☐	☐	☐	☐	☐	
2	Do you feel that the service has helped you to better understand and address your difficulties?	☐	☐	☐	☐	☐	
3	Did you feel involved in making choices about your treatment and care?	☐	☐	☐	☐	☐	
4	On reflection, did you get the help that mattered to you?	☐	☐	☐	☐	☐	
5	Did you have the confidence in your therapist and his /her skills and techniques?	☐	☐	☐	☐	☐	
6	Did you receive the employment help that you required?	☐	☐	☐	☐	☐	☐

Please use this space to tell us about your experience of our service so far

Thank you very much. We appreciate your help.

First Name……………………………….
Surname…………………………………
Date of Birth……………………………..

Understanding outcome measures

The following information has been taken from the Improving Access to Psychological Therapies Executive Summary (October 2016) and provides more detail on the concepts of recovery, reliable improvement and reliable recovery in IAPT services.

Caseness

'Caseness' is the term used to describe a referral that scores highly enough on measures of depression and anxiety to be classed as a clinical case. It is measured by using the assessment scores that are collected at IAPT appointments; if a patient's score is above the clinical/non-clinical cut-off (also known as the 'caseness threshold') on either anxiety, depression or both, then the referral is classed as a clinical case ('at caseness').

Depending on the measure used, a referral is at caseness if it meets the following cut-off score criteria:

- Agoraphobia-Mobility Inventory (AMI) ≥2.3
- Body Image Questionnaire (BIQ) Weekly ≥40
- Chalder Fatigue Questionnaire (CFQ) – ≥19
- Francis Irritable Bowel Syndrome Symptom Severity Scale (IBS-SSS)– ≥75
- Generalised Anxiety Disorder Assessment (GAD-7) ≥8
- Health Anxiety Inventory (HAI) (Short Week) ≥18
- Obsessive-Compulsive Inventory (OCI) ≥40
- Panic Disorder Severity Scale (PDSS) ≥8
- Patient Health Questionnaire (PHQ-9) ≥10
- Patient Health Questionnaire (PHQ-15) – ≥10
- PTSD Checklist for DSM-5 (PCL-5) ≥32
- Social Phobia Inventory (SPIN) ≥19

Recovery

Patients are considered **recovered** if their scores for depression and/or the recommended anxiety/MUS measure (see Table 2) are above the clinical cut-off on either measure at the start of treatment and their scores for **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 (less than 2%) number of patients who have missing post-treatment data are coded as not recovered.

Reliable improvement and reliable deterioration

Patients are considered **reliably improved** if their scores for depression and/or the recommended anxiety/MUS measure (see Table 2) have reduced by a reliable amount and neither has shown a reliable increase. Conversely, patients are **reliably deteriorated** if their scores for depression and/or the recommended anxiety/MUS measure (see Table 2) have increased by a reliable amount and neither measure has shown a reliable decrease.

In national reports **reliable improvement** and **reliable deterioration** rates are calculated from the total cohort of individuals who have completed a course of treatment (two or more sessions followed by discharge). **Recovery and reliable recovery** rates are only calculated from the cohort of individuals who met caseness criteria at the start of treatment.

Reliable recovery

Patients are considered **reliably recovered** if they meet both criteria for **reliable improvement** and for **recovery**.

H.4 Web-based resources

National guidance

Adult Community Mental Health Framework:

The Five Year Forward View for Mental Health

Implementing the Five Year Forward View for Mental Health

NHS England Five Year Transformation Programme for Perinatal Mental Health

Improving Access to Psychological Therapies (IAPT) Waiting Times Guidance and FAQ's

The NHS Long Term Plan

The Improving Access to Psychological Therapies (IAPT) Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms: Full implementation guidance

National Vision for the Psychological Professions in England

Resources on IAPT background and context

Adult Psychiatric Morbidity Survey

Oxcadat Resources

Resources on IAPT

Description of early implementer sites (IAPT-LTC services)

Map to show location of Wave 1 early implementers

Improving Access to Psychological Therapies Data Set (NHS Digital)

Submitting IAPT Dataset (NHS Digital)

Annual report on the use of IAPT services, England 2019-20 (NHS Digital)

Improving Access to Psychological Therapies (IAPT) Dataset Reports

NHS England: Adult Improving Access to Psychological Therapies programme

Public Health England (PHE) Common Mental Health Disorders Profiling Tool

Resources on integrating physical and mental health services

Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults

Better Care Fund strategies

Bringing Together Physical and Mental Health

King's College London: Integrating mental and physical healthcare

Long-term Conditions and Mental Health: The Cost of Co-morbidities

Integrated Personal Commissioning Programmes

New care models

Sustainability and Transformation Plans

NHS England value framework and logic models for IAPT-LTC

Organisation websites

Association of Christian Counsellors

British Association for Behavioural & Cognitive Psychotherapies

British Association for Counselling and Psychotherapy

British Association for Mindfulness Based Approaches

British Psychoanalytic Council

British Psychological Society

Care Quality Commission

EMDR UK

EMDR Ireland

Health Education England

Interpersonal Therapy UK Network

Mental Health Innovation Network

National Counselling Society

NHS Benchmarking

NHS Digital

NHS England

NHS Improvement

The Psychological Professions Network

Public Health England

Royal College of General Practitioners

Royal College of Psychiatrists

United Kingdom Council for Psychotherapy

Other helpful resources

NHS Staff Mental Wellbeing Hubs

MindEd mental wellbeing resources, including for staff.

Useful resources on staff wellbeing can be found on the Mind website.

'The Psychological Wellbeing Practitioner (PWP) Code': Professional Standards of Practice, Performance and Behaviour, developed by the North West PWP Professional Network with support of the North West Psychological Professions Network.

TranzWiki from the Gender Identity Research and Education Society provides useful information on supporting LGBT people.