

Commissioning a Brighter Future

Improving Access to Psychological Therapies

May 2007



DH INFORMATION READER BOX

Policy HR/Workforce Management Planning Clinical	Estates Performance IM & T Finance Partnership Working
Document purpose	Best Practice Guidance
Gateway reference	8165
Title	IAPT Positive Practice Guide
Author	CSIP Choice and Access Team
Publication date	10 May 2007
Target audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Local Authority CEs, Directors of Adult SSSs, NHS Trust Board Chairs, Directors of HR, GPs, Communication Leads, Directors of Children's SSSs
Circulation list	Voluntary Organisations/NDPBs, Mental Health Service User Networks
Description	The purpose of this document is to provide organisations with examples of best practice in the provision of Psychological Therapies in England
Cross reference	Improving Access to cCBT Implementation Guidance (March 07)
Superseded document	N/A
Action required	N/A
Timing	N/A
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For recipient's use	



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Foreword

Everyone in our society has a right to make choices about how they live their lives and contribute to the communities in which they live. Unfortunately, for many people who suffer from depression and anxiety disorders, these opportunities are often limited.

One in six people in England are affected by these common mental health problems at some point in their lives – more than will suffer from cancer or coronary heart disease.

In the past, the problems faced by sufferers and their families were not properly addressed by a society still breaking down the stigma and discrimination of mental ill health and a National Health Service that has not consistently offered access to effective psychological treatments.

As a society, we cannot allow this situation to continue – it is a tragic waste of the lives and potential of the individuals and families affected by this debilitating condition. It is also expensive to the taxpayer and businesses which must bear the costs of inadequate NHS treatment, loss of employee productivity and benefit payments to long-term sufferers.

As a Government, we are determined to improve support and tackle stigma and discrimination for people with common mental health problems.

Successful psychological therapies ensure that the **right number** of people are offered a choice of the **right services** at the **right time** with the **right results**. This document explores how these principles can be delivered and provides examples of positive practice from across the country. In particular, it focuses on the successes of the pilot sites that we established in 2006 in Doncaster and Newham, where local services have developed in new ways to rise to these challenges.

We will build on these achievements by creating *Pathfinder* sites that will bring further help to thousands of people.

Patricia Hewitt
Secretary of State for Health



Purpose and vision

Purpose

Everyone in society has the right to make a difference within their local community, but some can be restricted by their mental health problems.

This document describes services that provide everyone with depression and anxiety disorders with access to the right treatment. It also sets out the learning so far from the demonstration sites.

It is intended to be used to inform the development of a further 10 Pathfinder sites. Other commissioners who wish to review their current services and consider improvements to their services can also use it.

The treatment should include the most modern forms of psychological therapies, which, as the evidence shows, can help the majority of those affected back to health.

This support should come about by providing easier access to better psychological therapies and support services at the time when they are required. The information in the next few pages will help improve the health and well-being of the general population as proposed in the *Our Health, Our Care, Our Say* White Paper (Department of Health 2006).

It will:

- set out key service principles that define 'Improving Access to Psychological Therapies' for the Pathfinder sites;
- set out a framework that describes how we can expand services to improve access to psychological therapies for the Pathfinder sites; and
- demonstrate how many sites across the country are already making a difference and improving people's lives as a result.

Vision

The **Improving Access to Psychological Therapies** (IAPT) programme is concerned with raising standards of recognition of, and treatment for, the mass of people who suffer from



depression and anxiety disorders. The programme is at the heart of the Government's drive to give greater access to, and choice of, talking therapies to those who would benefit from them.

This document disseminates the learning and service principles from existing pilot programmes across the country to work towards tackling the debilitating impact of untreated depression and anxiety disorders in our society.

There should be a focus on the needs of local communities by promoting the provision of effective clinical services. It is intended that this will be complemented by better vocational and information services, and will involve service users, carers and voluntary organisations in offering integrated services focused on patients' needs.

It is envisaged that the programme would improve not only the health and well-being of the population but also promote social inclusion and improve economic productivity. Benefits will be felt by all of the following groups:

Adults of working age, above all: by relieving their illness, improving their ability to work and reducing their dependence on benefits.

Perinatal depression: by reducing the distress caused by antenatal and postnatal depression that can have short- and long-term consequences for both mother and child.

Children and young people: by tackling emotional and behavioural disorders that are currently largely untreated.

Older people: by helping those suffering from psychological problems, including those caused by physical illness such as lung disease. This in turn will help reduce unnecessary hospital admissions, help reduce burdens on carers and allow older people to remain independent and meaningfully involved in their local communities for longer, reducing the demand for residential care.

Black and minority ethnic groups: by improving access to primary care mental health services and ensuring psychological therapy services are culturally appropriate for the local population and sensitive to the needs of people from these groups.

Offenders: by providing appropriate treatment and greater access to psychological therapies, thus reducing mental ill-health among offenders and supporting their potential for rehabilitation.

People with long-term conditions: by improving the mental health of people with long-term conditions such as diabetes, chronic obstructive pulmonary disease (COPD), heart disease or stroke, which may help to improve their physical health outcomes.



Positive practice example – Black and Minority Ethnic groups

Service: Chinese Mental Health Association

Locality: London

Focus: CBT; cultural sensitivity; open access

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www.cmha.org.uk/

The Chinese Mental Health Association (CMHA) carries out preventative community development and educational projects as well as delivering family therapy and counselling to better support Chinese young people (aged 16 to 25) who experience psychological problems, as well as those who are at risk of developing psychiatric symptoms.

It is essential that CMHA practitioners are able to share and show understanding of value conflicts arising from traditions and customs. Clients often express the need to be understood when their distress is rooted in cultural conflicts, indicating that, when certain issues have to be addressed, counsellors who share the same cultural background are more understanding. Time spent explaining the fine details of the culture itself is reduced and the discussion is therefore more focused and less likely to detract from the issues at the core of the clients' problems. This promotes a therapeutic bond at an earlier stage of therapy and counselling.

An open referral system facilitates easy access to the service. Evaluation of the service has proved positive, with families and young people valuing the opportunity to discuss their problems in a culturally sensitive environment.



Positive practice example – Perinatal depression

Service: Changing Minds Centre for Education and Service Development

Locality: Northamptonshire PCT

Focus: Training to support primary care: care pathway protocol; maternal mental health

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www.northamptonshire.nhs.uk/Changing_Minds_Education_Centre/index.htm

The Changing Minds Mental Health Education and Development Centre is an innovation in education and training, providing learning and development on mental health issues across the health and social care sectors. Partners include service users and carers, secondary care services, the acute care sector, the independent sector and primary care. The centre has developed a distance learning training aimed at equipping practice nurses and associate practitioners with the skills, knowledge and confidence to work more effectively with mental health problems. It has trained community matrons and health visitors, as well as supporting the maternal mental health strategy in the locality.

The following is an example of how training in evidenced-based approaches and improving access to psychological therapies can help postnatal women:

Carol came with her baby to the health visitors' (HV) clinic to have her daughter weighed. Ann, a newly qualified HV, noticed that Carol seemed anxiously attentive to her new baby and had a chat with her at the end of the clinic. They talked for a while with Ann asking how Carol was managing with her toddler and the new baby. Carol spoke of needing to get it right for her children and became upset when talking about the type of mother she felt she was. At the end of the conversation Ann remarked that she had recently been reading a book that talked about 'good parenting'. The book advocated a strict timetable for the care of a baby with set times for feeding, play and sleep.

Ann remarked that the book seemed to contradict Carol's own intuitive mothering. On further exploration, it transpired that Carol had a very critical father and she had never felt good enough for him. There was little encouragement and support shown in the family as she was growing up and she was left very anxious about getting anything wrong.



Service: Changing Minds Centre for Education and Service Development (cont.)

Ann offered to see Carol at home the following week and used the Edinburgh postnatal depression scale to see if she was depressed as well as anxious. They discussed the fact that Carol was mildly depressed and identified a number of strategies that would assist her, one of which was to change some of her negative thinking and she was encouraged to have confidence in her own ability. Ann agreed to phone Carol twice at set times over the next fortnight. Ann felt confident about adopting this role after her recent training as she felt she understood more about the skills and evidence base of CBT. She also had access to a 'clinical supervisor', a psychologist from the Primary Mental Health Team, if required. Ann discussed Carol with her supervisor and they both decided that she did not need to 'step up' to further care.

Carol used the 15 minutes on the telephone well and decided to throw the parenting book away. Her confidence grew and her self-esteem improved and she worked on developing strategies to cope with those times when she felt useless and a failure. Ann could see how effective the strategies were and she now says she feels much more able to respond appropriately to other new mums with symptoms of depression and anxiety.



Our challenges – the case for change

The scale of the problem should not be under-estimated. Mental ill-health accounts for over a third of all illness in Britain and 40 per cent of all disability. Many people in different communities are affected:

- one in six working adults (16 per cent of the population) at any one time are suffering from clinical depression and/or anxiety disorders;
- 700,000 children and younger people in England and Wales have mental health problems, which can lead to anti-social behaviour and poor educational achievements;
- 1.3 million older people suffer from depression and mental illness, with this figure set to rise as the population ages;
- among the 7 million carers, one in ten men and one in five women report some form of mental illness; and
- 10 per cent of new mothers suffer from postnatal depression, of whom, reports suggest, fewer than one in five receive psychological treatment.

Because evidence-based psychological services have not been universally available, many of these people do not come forward for treatment and, for those who do, treatment has often been limited to the prescribing of medication or referral on to specialist/secondary mental health services.

We now have the opportunity to tackle these challenges because we know that psychological therapies work. We now need to make sure that people are able to access them.

Best practice shows that it is possible to expand the general availability of socially inclusive interventions and evidence-based treatments by delivering more systematic and effective services. In the areas of positive practice, we have identified the following key service principles.



Modern psychological therapy services – key principles

To support local systems considering effective ways of developing these services, the following four best practice principles and approaches have been identified, which will form the basis of the Pathfinder sites in 2007.

Right number, right services, right time, right results

1. **Right number of patients seen:** understanding the level of need across your community and **maximising services** to meet those needs.
2. **Right services:** providing **effective treatments and interventions** within a **stepped care** framework delivered by an **appropriate** and **competent** workforce.
3. **Right time:** improved **access** to services for people with depression and anxiety disorders – both in terms of the **numbers** of people being treated and the **waiting times** they can expect from service providers.
4. **Right results:** collecting and delivering routine **outcome data** across the four domains of improved Health and well-being, social inclusion and employment, improved choice and improved patient experience.

1. Right number

The key challenge will be to review the number of people who experience these conditions locally and understand how many of those currently come forward for treatment.

Health Needs Assessment

The initial step for any primary care trust (PCT) or practice-based commissioner in establishing an understanding of what talking treatments and inclusive interventions would best meet their community's health needs, would be a Health Needs Assessment. This will provide information that can be used to populate the service and outcome models.

Delivering services that most closely match the needs of the local community would entail working in partnership with stakeholders, clinical and therapeutic staff, and public health departments.

Following the initial Health Needs Assessment, commissioners will need to work with services and their workforce to look at using service redesign techniques to achieve these requirements.



Positive practice example – Right number

Service: Primary Care Psychology Service (PCPS) and Primary Care Mental Health Service (PCMHS)

Locality: Salford PCT and Bolton, Salford and Trafford Mental Health Trust

Focus: Public Health Needs Assessment; service redesign

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Public health data shows that Salford has major urban deprivation and mental health problems. Key issues were (1) a long waiting list for more specialist psychological therapy services; and (2) a lack of comprehensive provision of services for people with milder conditions (step 2 of the stepped care model).

The **service redesign approach** included: a public Health Needs Assessment and use of local intelligence; a joined up 'whole system' approach; a creative use of remaining resources; utilising partnership and team working to build morale and increase productivity.

Systematic Process

- Phase 1 Psychology services modernised: 1,000 people on waiting list rapidly screened.
- Phase 2 Treatment offered to the 600 people who required it – utilising stepped care approach.
- Phase 3 Operational changes: earlier assessments, duration of therapy limited to a set number of sessions, proactive case management, and stricter policies on missed and cancelled appointments.
- Phase 4 Reorganised clinical teams into four regional sub-teams in PCT localities.
- Phase 5 Agreed on definition and use of the stepped care approach; key service elements linked to this.
- Phase 6 New Primary Care Mental Health Service set up using collaborative care model. Appointed graduate mental health workers and GPs with special interests who work with a sessional consultant psychiatrist and CBT therapist. Developed links between primary care and other services, including the Third Sector.

Learning:

Whole system approach works; funds scarce, so use what you have wisely; great added benefits from working with others; public Health Needs Assessment is crude – much needs to be done regarding protocols and pathways; changes to operational systems and reorganisation of local teams resulted in the waiting time cut for initial assessment.



2. Right services

Alongside improving access, services also need to be able to provide the most effective psychological interventions available that are appropriate to meet the needs of the local population.

Highlighting the different needs and requirements of those with mental ill-health, the stepped care approach indicates the responses and treatments required from services at different levels of need. Delivering effective interventions would require a workforce with the skills to meet the various demands at the different levels of intervention within the stepped care approach.

The idea is simple: to provide patients with the most cost effective and appropriate treatment, in the least invasive manner, as close to home as possible.

The key will be to provide an adequate scale of treatments as recommended in the guidelines issued by the National Institute for Health and Clinical Excellence (NICE).

Although treatments vary according to the individual's condition, the stepped care approach advocates that a person should start with the least intensive treatment which offers a reasonable prospect of success, and, if necessary, should then 'step up' to a more intensive treatment. This is based on the Kaiser Permanente risk stratification model¹ broadly outlined in figure 1.

Figure 1: *The stepped care model*



For different disorders, the interventions recommended by NICE can be found at <http://guidance.nice.org.uk/topic/behavioural>

When adapted to reflect local requirements, the stepped care approach will enable local services to determine the correct therapeutic interventions for each step, the professional input required, as well as the ideal skills mix. The stepped care model should also assist PCTs in managing their resources more effectively.

¹ <http://xnet.kp.org/permanentejournal/winter00pj/conversation.html>



Positive practice example – Right services

Service: Gloucestershire Primary Care Development Team

Locality: Gloucestershire PCT and Gloucestershire Partnership NHS Trust

Focus: Workforce; CBT competency; graduate mental health workers (GMHWs)

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www.pmhtglos.org.uk/

Mental health services in Gloucestershire offer interventions in a stepped care approach at steps 1 to 3: delivering bibliotherapy: guided self-help workbooks; stress management courses in local colleges; and computerised CBT (Beating the Blues) within a stepped care, triage assessment system. Services are also provided in GPs' surgeries, over the telephone in accordance with patient need and following NICE guidelines. Community Mental Health Teams have been recently redesigned as Primary Care Assessment and Triage Teams (PCAT) and the national target for recruitment for GMHWs has been exceeded.

Recognising the need to improve access at step 3 (moderate presentations), 24 practitioners, including 12 GMHWs were trained in conjunction with Oxford Cognitive Therapy Centre in foundation CBT skills. With a caseload of 16 patients each for an average of 12 sessions, interventions are delivered face-to-face and by telephone, thereby greatly increasing patients' access to CBT. Supervision is provided by a qualified clinical psychologist as well as peer support. Evaluation methods included the 'blind' rating of audio tapes by CPT experts using the Cognitive Therapy Scale (CTS) which demonstrated an impressive level of competency, particularly in GMHWs. Improvement in competency was noted across all domains of CTS. Courses and further 'master classes' are offered.

The clinical effectiveness of interventions is evaluated using Clinical Outcome for Routine Evaluation (CORE), a tool designed to measure clinical outcomes as part of a routine evaluation process. High levels of patient satisfaction have been reported. The GMHWs themselves provide enthusiasm and ambition; their ability to develop themselves and adherence to protocol make them a group of staff offering a pragmatic approach to improving access to psychological therapies. Retention of this competent workforce has also improved.



Positive practice – Right services

Service: Leicester, Leicestershire and Rutland Common Mental Health Service

Locality: Leicester, Leicestershire County and Rutland PCT

Focus: Social inclusion; equality agenda; asylum seeker support

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The Common Mental Health Problem Service has three unique features: access, workforce and diversity of provision. It is a locally accessible service provided in all GP surgeries; its staff are very experienced mental health professionals who provide assessment and a range of psychological therapies within a stepped care model. The service serves a population of 900,000 and encompasses a diverse population from sparsely populated rural areas to deprived inner city areas where almost 50 per cent of the population are members of an ethnic minority community.

The service also provides specialist clinics for two unique primary care surgeries: the Leicester Homeless Primary Health Care Service and the ASSIST service which provides primary care services for the city's growing population of asylum seekers and refugees. Hawa's story illustrates some of the work that is undertaken.

Hawa fled Somalia during the tribal conflict in 2003. She was 24, her husband had disappeared and her four sisters and parents had been killed during an attack on her village. She had been captured and held in detention where she suffered beatings and was gang raped.

She remembers little of her escape and journey to England. Her asylum application took two years to process and was refused. Hawa was terrified of returning to Somalia and refused to sign a section 4 (a process by which asylum seekers whose application to remain in the country has been rejected receive food vouchers and accommodation on the understanding that they will return to their country of origin when safe to do so) which resulted in her being destitute. It was at this point that she came to the practice. Hawa was experiencing visions and hearing the voices of the men who captured her and raped her, she spoke little English, was emotionally detached, sleeping on the street and eating infrequently.

The service arranged for her to have medication but she could only take it when she had somewhere safe to sleep. The service worked hard to find accommodation and gave her details of where she could get a free meal, shower and change of clothes. They met almost weekly and gradually her story emerged. Hawa responded well to the medication and the opportunity to talk about her traumatic experiences. She is now well and going to college to learn English. Her future remains uncertain, however, and her story, though distressing, is not exceptional for members of this community.



3. Right time

People should have prompt access to the services they need to ensure that their problems are quickly resolved. This in turn will reduce the social impact on the individual who, if left untreated, might continue to experience these problems over many years.

We have worked with service users and carers to establish the most reasonable length of time that people would expect to wait for psychological therapy services. We have identified that best practice sites are working towards achieving maximum waiting times of ten working days from referral to treatment for people with mild or moderate conditions. We recommend that services begin to monitor the delivery of waiting times at key points on the care pathway – from referral to treatment at each level of the stepped care model.

Positive practice example – Right time

Service: Mind – therapeutic groups

Locality: Oxfordshire

Focus: Third sector providers; integrated working

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Oxfordshire Mind has developed and delivered therapeutic groups based on CBT techniques. These covered three topics: Coping with Depression, Coping with Anxiety and Building Self-esteem. They were supervised by a clinical psychologist seconded from Oxfordshire and Buckinghamshire Mental Health Partnership NHS Trust and facilitated by CBT-trained Mind workers. Participants heard about the service through primary care, community mental health teams and Mind publicity. Outcome measures showed positive clinical outcomes and positive satisfaction scores for participants.

Participants' comments include:

"I have had counselling from various sources over the last 10 years, but this is the first time I have discovered the root of my problems and have the tools to change them."

"Overall I have been pleased with the 10-week programme. It has contained ups and downs but it has allowed me to step off the rollercoaster of my life and try to develop a balanced outcome."

"The Mind anxiety management group was the first time anyone had ever taught me a way of coping with my anxiety so that I felt I had actual methods to fight the overwhelming emotions."

The service operates from a range of non-clinical venues across Oxfordshire. To maximise access groups are organised at times that are convenient for people who are busy during the working day. To encourage engagement with younger people Oxfordshire Mind are also working in partnership with local education providers.



4. Right results

Positive practice shows that sites have been able to demonstrate to patients, commissioners and the public that they are effective in improving the health and well-being of people they treat. The demonstration sites have developed and organised services flexibly, and have provided standard outcomes data that has been consistently monitored. We recommend that services should be able to demonstrate that they can deliver outcomes that address the following questions:

- Are the services effective in meeting the expectations set out in the NICE guidelines?
- Do the services promote social inclusion by showing that patients are better able to participate in society?
- Are people able to make choices about the services they receive?
- Are people able to shape the services and influence their future development?

Outcomes data

To achieve regular and consistent monitoring of outcomes data, the IAPT outcomes framework has been developed. This will be further refined by the IAPT Pathfinder sites, but is now available to support local systems as best practice. The framework identifies the following outcome domains:

Figure 2: *Health and well-being outcomes framework*





Positive practice example – Right results

Service: Primary care Trailblazers programme

Locality: National

Focus: Long-term conditions; integrated clinical management

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For more information regarding Trailblazers also contact your Regional CSIP Primary Care or IAPT lead

Trailblazers promotes well-being through actioning service redesign, personal and workforce development, and creative partnerships. Each cohort, of approximately 20 participants, identifies a partner from an organisation with whom its members can work to improve patient care by exploring innovative ways of developing integrated working. Trailblazers provides an opportunity to work as part of a pair/trio over a 6-to-12-month period and learn with like-minded people working at the generalist specialist interface, to define and meet individual, organisational and locality needs. The programme encourages leadership potential and is delivered over three two-day residential modules.

The following case study demonstrates how providing the right environment allows practitioners to reflect on how they can support real change in practice and improvement in health. Louisa and Kathryn attended Trailblazers in 2006, identifying a need to incorporate CBT into their repertoire of skills to support people managing long-term conditions. Having identified how to access local training and supervision, they were keen to get started.

Kathryn, a newly appointed community matron, and Louisa, a practice nurse, decided to work together to identify 10 patients with chronic obstructive pulmonary disease (COPD) and visit them all. When they visited Mr Shepherd they found he was depressed and very worried about his wife's failing health. He mentioned that his wife had recently lost a close friend and that she was finding it difficult to cope with the restrictions that his COPD had placed on their lives. At assessment both Mr and Mrs Shepherd recognised that they were not managing very well. They were feeling irritable with each other and unsupported.

Kathryn worked with Mr and Mrs Shepherd in a structured way using brief CBT techniques to help them think about their situation and try to approach things in a different way. They both made progress. Mrs Shepherd met up with a friend and was contemplating attending a 'Loss and Change' course run by her primary care mental health service, while Mr Shepherd was encouraged to participate in an Expert Patient group which he attended with Louisa without whom, he said, he would not have felt able to go.

On reviewing Mr and Mrs Shepherd, Kathryn and Louisa found that they had each reduced their visits to the surgery by 40 per cent and 30 per cent respectively and Mr Shepherd had not been admitted to hospital for nine months – he is hoping to make that 10 which will be a record for him. Neither Mr or Mrs Shepherd is taking any medication for depression and a repeat Hospital Anxiety and Depression Scale (HADS) rating confirmed they were no longer depressed or anxious.



Achieving the vision – promoting a commissioner-led approach

PCTs are key in helping to deliver the vision by considering what is required to commission the appropriate range of talking therapies to meet the common mental health needs of the local community.

The major problem to be tackled lies in addressing the needs of people who suffer from depression and anxiety disorders – conditions which are experienced by one in six adults in England at some stage in their lives.

Practice-based commissioning (PBC) will offer the opportunity to provide innovative, whole person care. Across the country, practice-based consortia are developing psychological therapy services aimed at improving people's ability to manage long-term physical health conditions, such as diabetes and heart disease, through the positive management of their mental health.

The new Pathfinder sites should seek to harness GP leadership, both through PBC and through encouraging more GPs with a special interest in mental health services, to develop local solutions to patients' needs.

Key to the planning process for the Pathfinder sites will be a focus on:

- **Assessment:** the overall locality Health Needs Assessment will highlight the key areas for continual review as locality needs change over time; it will also be used as the basis for future service development;
- **Care pathway development:** the local care pathway should describe the way in which patients move through the stepped care process, by whom they are treated and at what point; and
- **Service redesign:** by comparing local health needs with current service provision, localities will have the opportunity to improve services by using the best way of organising services within a stepped care framework.

The local needs assessment will determine how services and the workforce should adapt to deliver effective and efficient services for patients. Service improvements will highlight how the service is to be delivered to patients, by whom and at what point to ensure that the right number of people are being supported at the right time, with the right services, and right results.



Positive practice example – Promoting a commissioner-led approach

Service: Exeter and East Devon Mental Health Network

Locality: Devon PCT; Devon Partnership NHS Trust

Focus: Whole system redesign; Commissioning Led; Partnership working

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David Jeffery, david.jeffery@nhs.net

With a clear commissioning vision, a four-way partnership has been set up between Devon PCT, Devon Partnership NHS Trust, local GPs and independent contractors to develop new ways of working. The Health Community in Devon and Torbay has therefore committed to a major redesign of mental health and well-being services through the creation of networks of integrated support and care.

Managed networks, or organisation frameworks, create a coherent 'whole system' using:

- traditional line management within organisations;
- contracts and service level agreements; and
- planning and delivery frameworks used within the local area agreements.

Within the networks the following principles have been applied:

- Develop a Mental Health Needs Assessment as the starting point for change.
- Offer value-driven personalised care.
- Avoid hand-offs and multiple assessments between primary care and specialist mental health services.
- Offer the least intrusive help, first time.
- Increase access to supported self-help and self-directed care.
- Maintain social inclusion and support employment, training and education within the context of a recovery model.

The innovative primary care mental health access and treatment team, which includes an advanced nurse practitioner, assistant practitioners, graduate mental health workers, volunteer counsellors and community mental clinicians, covers a number of market and coastal towns. It works closely with non-statutory providers and the voluntary sector. It has shown increased capacity and a range of services along a stepped care pathway and has integrated access to primary and secondary services to deliver more robust care pathways for those experiencing common mental health problems.



Talking therapies

Talking therapies is a broad term covering a range of therapeutic approaches, which involve **talking, questioning** and **listening to understand, manage** and **treat** people's problems.

The treatment includes counselling, cognitive behavioural therapy (CBT), psychoanalysis and psychodynamic therapies.

Interventions, treatments and psychological support offered by a range of services

Bibliotherapy

The prescription of free, self-help books, from local libraries can help people 'narrow down' what reading materials may help them to manage their anxiety or depression. It also offers opportunities for community engagement. Offering telephone support with the recommended books will enhance the effectiveness of the outcomes.

Psychological therapies

Face-to-face therapy such as counselling, CBT, interpersonal psychotherapy, psychodynamic therapy, and other forms of psychotherapy.

Guided self-help (psycho-education)

Using booklets and information to help people.

Computerised CBT

Delivery of CBT via an interactive computer program such as Fear Fighter (for treating people who have phobias or suffer from panic attacks) and Beating the Blues (for treating people with mild to moderate depression).

Information and support

Information, assistance and guidance to help people find out about training, education and job opportunities and access to appropriate support.

Telephone support

A brief intervention of cognitive behavioural therapy and other evidence-based approaches delivered by appropriately trained staff.

Prescribed activity

Such as exercise, social activity, participation in the arts or education.



Achieving the vision – the Pathfinders

In 2007, the IAPT programme will be extended via a number of Pathfinder sites across England.

In addition to the Newham and Doncaster demonstration sites, up to a further 10 Pathfinder sites will be established.

The aim of the new Pathfinder sites is to provide additional evidence and experiential learning to support the case, including affordability, for continuing the roll out of psychological therapy services for people with anxiety disorders and depression.

Clear evidence will be required to demonstrate how psychological therapies can deliver real and significant benefit in terms of health and well-being gains to patients, healthcare efficiencies and resource savings in the NHS.

The collection and analysis of robust evidence will be one of the key priorities in 2007/08.



The demonstration sites

In 2006, demonstration sites were established in Newham and Doncaster, along with a national network of 23 local pilot sites across England.

These sites provide evidence-based psychological interventions and support for people with mental health illness in primary and secondary care settings.

The demonstration sites: a snapshot of clinical intake in 2006/07

Newham IAPT demonstration site

The clinical intake after six months of the pilot up to January 2007 indicated:

- **89 per cent** of service users had had an episode of illness lasting longer than six months;
- **74 per cent** had had an episode of illness lasting longer than one year;
- **32 per cent** had had an episode of illness lasting longer than five years;
- **over 75 per cent** scored moderate to severe on measures of anxiety and depression; and
- of those out of work, **76 per cent** had been unemployed for over a year.

Doncaster IAPT demonstration site

The clinical intake after six months of the pilot up to January 2007 indicated:

- **20 per cent** of patients suffered from depression, **73 per cent** suffered from mixed anxiety and depression;
- severely or moderate/severely depressed patients make up **64 per cent** of referrals, the equivalent statistic for anxiety is **54 per cent**;
- **43 per cent** of referrals are still in treatment, **13 per cent** have completed it, **5 per cent** have discontinued of their own accord; and
- two-thirds of referrals were women and one-third of patients were unemployed, **90 per cent** of whom received incapacity benefit.

Between **250** and **300** referrals were received each month.



Evidence collected from the two demonstration sites shows the benefits that modern psychological services can bring. The sites have described these in terms of the 'balanced score card':

Mental health and well-being

- offering a range of psychological interventions are clinically effective, for instance guided self-help, computerised CBT and bibliotherapy
- Helping patients improve, with the majority reporting either no, or significantly reduced, clinical symptoms of depression and/or anxiety

Social inclusion and employment

- Helping long-term Incapacity Benefit claimants back to work
- Keeping people who have mental health problems in work
- Helping people interact better in a community to enable them to make the choices they want to live a meaningful life

Improved choice and access

- Increasing understanding on how to meet the psychological needs of minority communities which are often excluded from mainstream treatment because of gender or language and cultural differences
- Improving effectiveness of services by changing the traditional ways in which they are accessed, for instance moving services from being delivered in clinical environments, which some find stigmatising
- Giving people greater control over when, where and how they access treatments by using technology to increase the flexibility of delivery
- Giving people a real choice by offering treatments from face-to-face therapy, to books on prescription

Improved patient experience

- Reducing waiting times and referrals to specialist services by treating the majority of people in primary care
- Ensuring high service satisfaction, with the majority of patients choosing psychological interventions rather than other treatments, such as medication
- Enabling GPs to provide better primary care services for people with mental health problems by having more treatment options, rather than simply prescribing drugs or referring to secondary services



Newham IAPT demonstration site

Personal statement

Hello, my name is Blue Middleton

I am 41 years of age. I have suffered from depression for the past 22 years, the latter 15 years being my worst. My additional symptoms are chronic anxiety, insomnia, and I encounter panic attacks from time to time. In addition to this, for the past three years of my life I have suffered with severe IBS (irritable bowel syndrome), which has a considerable effect on my physical state.

My first dealings with approaching a general practitioner with regards to my depression was when I was 19 years of age. I was, without being asked any questions, given medication in the form of diazepam. This resulted in exacerbating my state. I felt there was no understanding with regards to my condition. Although I was in a happy relationship and full-time employment, I felt isolated within myself. I was unable to discuss my thoughts openly with friends and work colleagues due to stigma; you could understand that being a young man at this time was difficult.

As time progressed my depression went untreated, due to fear. As I then matured to my late 20s early 30s I had made new friends with whom I felt able to discuss my innermost feelings. By this time I was encountering panic attacks and insomnia. Although I had found understanding friends I still felt very much alone, with my illness. A progression of bad things happening in my life led me to seek out counselling, in the short term this seemed to be the support I needed. Once the counselling sessions had come to an end, I felt yet again alone and without direction – to put it briefly, the counselling was a good “weekly outlet”. The following few years I had tried with the help of a doctor several antidepressants, which did not work, they often left me in a state of confusion.

Hitting 40 years of age and under guidance of my long-term GP I was offered a new service offering CBT which was being implemented as a pilot scheme within my local area. Although having no understanding of CBT in itself, I felt in desperation, and for my life to move forward agreed to a course of treatment. In the past year I have achieved exactly my objectives set out in my first session with my therapist, that of being more confident within myself, and of having more control of the direction of my life. I am now taking steps to getting back into the workplace, after exploring several avenues in the past year. I am also currently co-chair of the Newham Psychological Treatment Centre Service Users’ panel and involved in various ongoing projects. Although these are small steps to onlookers they are significant steps to me, which could not have been possible without the help and support of CBT.

I am indebted to this treatment, and would recommend that this service become more widely available.

I have got this far... Thank you.



Doncaster IAPT demonstration site

Two case examples

Debbie, aged 36 and a single mum of three (one of whom had learning difficulties), was referred to Doncaster IAPT by her GP with feelings of low self-esteem and confidence. She had a difficult relationship with her partner due to his problems with drugs, drinking and gambling. She had left him on a number of occasions but had always returned even though she knew that it was not doing her any good. He always convinced her that he had changed. This never happened and she always ended up in the same situation, feeling low and not being able to assert herself enough to say no and mean no. Her lack of self-esteem and assertiveness also manifested itself in her relationship with food and she found purging enabled her to feel in control of something.

Following a series of nine telephone sessions, she was able to increase her self-esteem and confidence using CBT techniques (behavioural activation and challenging negative thoughts). This in turn helped her to feel better about herself in other areas of her life, including her social and leisure activities and she was able to join groups that helped her with her child's learning difficulties. Because she felt more confident in her own abilities, she was able to be more assertive with people and when a problem arose with her rented property she dealt with the landlord to get things sorted out – something that she had not been able to do before. Her purging stopped because she felt more in control of other areas of her life and felt better about herself generally. She also enrolled on a course aimed at improving assertiveness with a local voluntary women's agency and has since gone on to work with them as a volunteer helping other women in similar situations.

June, a 52-year-old administrator, was referred to the IAPT team by her GP. She had severe depression and anxiety (as rated by PHQ9 and GAD7 – two short questionnaires which are used to assess levels of depression and anxiety: Public Health Questionnaire and Generalised Anxiety Disorder). She was very anxious, suffered from poor sleep, loss of appetite, poor concentration, memory problems and lacked motivation and energy. She was unable to cope with most of her everyday domestic tasks, was not socialising and was unable to continue with her important and pressurised job. She was very tearful and feeling guilty and a failure for not being able to cope.

Her treatment consisted of a face-to-face assessment followed by 13 telephone appointments using guided self-help including low-intensity CBT. June re-established her domestic routine and social life using behavioural activation techniques, learned how to put her situation into context and to challenge her negative and unhelpful thoughts and to anticipate and cope with stressors.

At the end of her treatment she was feeling better, her symptoms had greatly reduced and she was able to return to work.



Next steps

During 2007

During 2007, the programme will be extended by the introduction of a number of IAPT Pathfinder sites. The next phase of implementation will apply the principles laid out in this document and contribute to the evidence.

Support will be provided to all PCTs that express an interest in the IAPT Pathfinder programme, to share the positive practice principles described in this document and to provide access to tools to enable them to apply them locally.

During 2008

Following the learning from the existing demonstration sites and the new Pathfinder sites, we will be developing plans for how these service improvements can be further disseminated. We will continue to collect positive practice examples to enable programmes to learn from each other.

We have already seen in a very short space of time that psychological therapies can help those suffering from depression or anxiety disorders. Other sufferers should therefore be offered the same opportunities to improve their health and well-being.



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281426 1p 0.5k May 07 (CWP)
Produced by COI for the Department of Health