

# IAPT OUTLINE SERVICE SPECIFICATION

## Improving Access to Psychological Therapies Programme (IAPT)

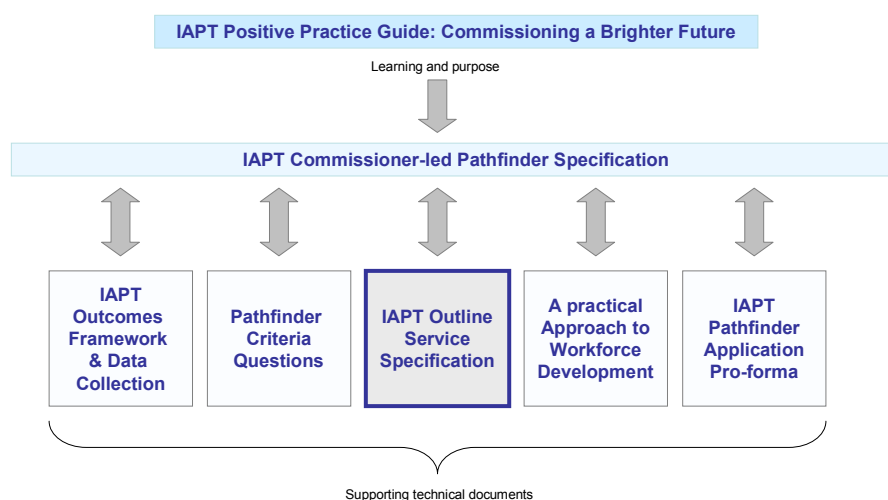
The IAPT Programme is a Department of Health initiative to improve access to psychological therapies. It was developed in 2005, following a white paper commitment in Our Health, Our Care, Our Say.

In 2006/7, the IAPT demonstration sites core purpose was to collect evidence of delivery to substantiate the development of a business case for a national roll out of the IAPT service model.

The programme is now going to establish a number of IAPT Pathfinder sites, which will use service redesign techniques to implement a defined care pathway, service specification, and service framework.

In addition to this document, the following documents are available to support the development of these Pathfinder sites

- IAPT Outcomes Framework & Data Collection
- Pathfinder Criteria Questions
- A practical Approach to Workforce Development
- IAPT Pathfinder Application Pro-forma



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## Summary

This Specification describes the mandatory features that are required of all the IAPT Pathfinder sites. The intention is to provide a broad framework which enables and encourages opportunities for service innovation of individual commissioners and providers.

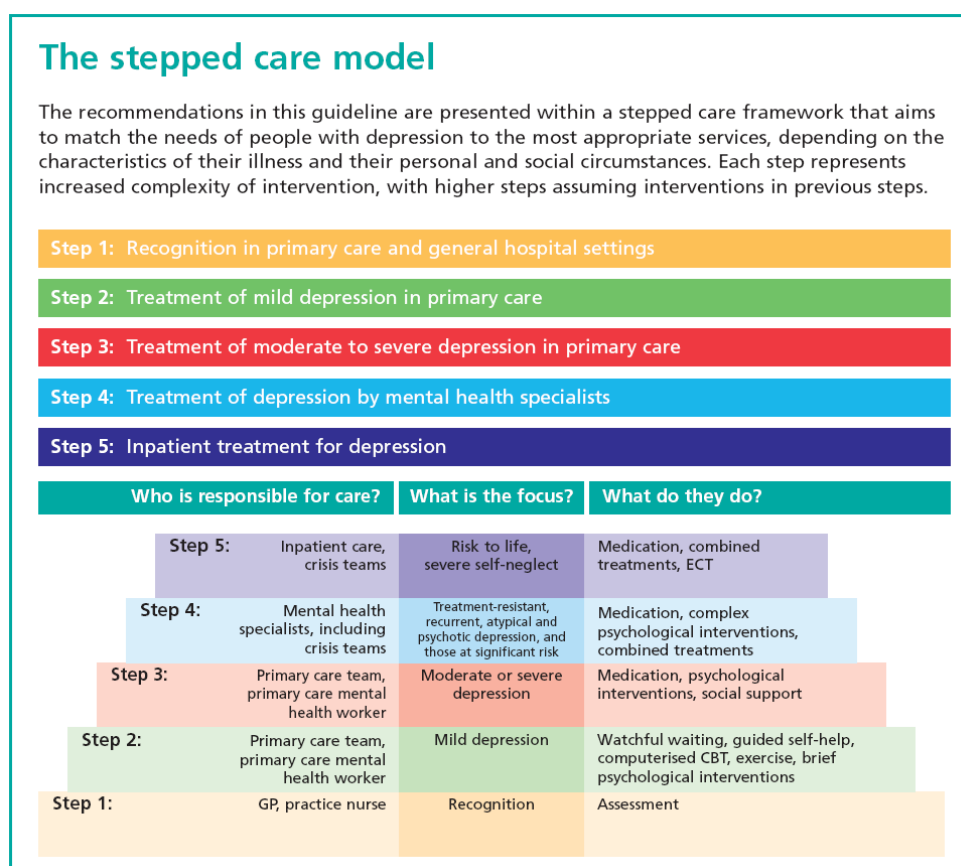
The main areas of commonality that must be delivered in any new service are:

- The provision of NICE approved treatments
- The use of a stepped care process of care for those conditions where risk stratification, and varying intensity of interventions, is appropriate and approved by NICE
- A system for data collection which supports the core requirements of the IAPT minimum data set (see IAPT Outcome Framework), including:
  - An increase of evidence based and informed choice by people who use the service
  - An increase in access to a range of evidence based treatment options

## Introduction

1. The NICE guidelines for the management of depression, anxiety (panic disorder and generalized anxiety disorder) and Obsessive-Compulsive Disorder (OCD), but not the Guidelines for Post-Traumatic Stress Disorder recommend using a stepped care model (the depression stepped care framework is shown in figure 1). The steps and the interventions required vary across these conditions, but the principle is that patients receive the least burdensome effective treatment necessary for their recovery.
2. Within stepped care, the progression of patients from step 1 interventions through to a higher step intervention is based on a mixture of increased need and past experience of treatment. As the NICE Depression Guidelines outline, it is expected that many patients will have had access to lower step treatments prior to receiving treatments from higher treatment steps. For example, many patients with moderate/severe depression will benefit from brief psychological interventions and this may reduce the burden on more intensive treatment on the patient and the service providers and commissioners.

**Figure 1 – NICE Stepped Care model for the treatment of depression**



## Aims

3. The key aims of the IAPT Pathfinder sites are to:

- Define the service to be provided across the Stepped Care spectrum, focusing particularly on the development of new low and high-intensity psychological therapy services in the early steps (2-4) of the relevant NICE model of care.
- Improve early access to and delivery of psychological therapies in primary and community settings.
- Provide a service that is evidence based and value for money.
- Provide access to information and other supports for people who are referred, but who may not at present be eligible for the service.

## Service Outline

4. The service will treat patients experiencing depression, panic disorder, generalized anxiety disorder, phobias, post-traumatic stress disorder, obsessive-compulsive disorder and body dysmorphic disorder. The IAPT expert reference group (ERG) has made the pragmatic recommendation that the stepped care

approach for the treatment of the disorders outlined above, where appropriate should be used. The patient journey around the blocks of services will be the responsibility of the provider.

5. The service will be delivered by a multi-disciplinary team:
  - i. At step 2 (depending on the specific interventions recommended by the relevant NICE guideline), low-intensity interventions will be delivered by a mix of workers with appropriate training, supported and supervised by professionals with the relevant competences.
  - ii. At steps 3 and 4 (again depending on the specific guideline), high-intensity interventions will be delivered by professionals competent in the delivery of CBT and other evidence-based interventions.
  - iii. The team will be supported at all steps by employment/housing/benefit advisors and by input from GPs with special interests (GPwSI).
6. **Step 2 service description.** This is generally a low-intensity service and will include the components below. It can be provided through individual and group sessions (when these are recommended in NICE Guidance) and will include both brief face-to-face contact and telephone support. Key elements:
  - Use of interventions detailed below (1-6 sessions, average 4 sessions):
    - Education
    - Bibliotherapy
    - Behavioural activation
    - Signposting
    - Guided cognitive-behavioural self-help
    - Problem-Solving
    - Guided self-directed exposure therapy
    - Referring to various services including social services and exercise referral
    - Introduction to services - this will require the worker to accompany the client to the required service if support is needed.
    - Computerised CBT (8 sessions)
  - Concomitant medication advice and support for patients receiving antidepressant medication
  - Telephone 'collaborative care' support for patients on antidepressant medication
  - Individual CBT sessions with a therapist (6-8 face-to-face sessions, average 7 sessions)
7. **Steps 3 & 4 (depending on the Guideline) service description.** This level is generally a high-intensity service and includes the following components:

- Individual CBT (8-20 sessions, average of 12 sessions over 6 months)
  - Group CBT (6-10 people, up to 12 x 2hr sessions)
  - Therapy sessions should be supplemented by guided self help when appropriate materials are available.
  - Concomitant medication advice and support for patients receiving antidepressant medication
  - Telephone 'collaborative care' support for patients on antidepressant medication
8. The provider will be responsible for case management and communicating with the service users GP when required, including referral to higher steps (specialist services outside the IAPT service, CMHTs, in-patient care).

### Service supplied

9. The service should deliver the **access** and **outcome** standards defined in the IAPT Outcome and Data Collection framework (see [www.mhchoice.csip.org.uk](http://www.mhchoice.csip.org.uk)).
10. All patients will initially be offered an assessment/screening, which will focus on the presenting problem, a basic risk assessment and referral on to other agencies, if appropriate. This will include the following elements:
- Prior to the start of treatment all patients should receive a comprehensive 'patient centred' assessment that clearly identifies the full range and impact of their mental health problems and any linked employment, social and physical health issues.
  - Risk (suicide, harm to others, etc) should be assessed at initial contact and at each contact thereafter.
  - All patients must have their clinical, work and social outcomes assessed using standardised measures that are appropriate to the conditions being treated. Key measures should be given at each treatment session so that a clinical end point is available even if patients finish treatment early.
  - Services should aim for pre to post treatment outcome data in over 95% of their patients.
  - **Access standard** - services are required to meet an access standard of 1 to 3 working days from Referral to Decision to Treat.
11. Once accepted the patient will be directed to the appropriate service step depending on their need; step 2, 3 or 4.

- **Access standard – 1 – 10 working days from Referral to Step 2 Treatment Commencing. NO more than 12 weeks to Step 3 or 4 treatment commencing if that is the first step.**

12. Following initial assessment patients will be offered low- or high-intensity stepped treatments as detailed above. This will include the following elements:

- All patients must be offered an evidence-based treatment appropriate to their condition, as indicated in current NICE Guidelines. Where several evidence-based treatments are recommended by NICE, patients should be offered a choice.
- The evidence-based treatment should be given at the minimum dose that is necessary to achieve full and sustained recovery.
- In addition to being offered an evidence based psychological treatment, patients may be offered an experimental treatment if the treatment is in the process of being evaluated and there are reasonable grounds to assume that it is likely to be effective. Patients should be informed in writing that the treatment is experimental.
- Responsibility for prescribing medication should normally reside with the patient's GP. However, the psychological therapy service should have expertise in how medication can be used in conjunction with psychological therapies. In this way, mental health workers within the service will be able to assist patients to make decisions about their use of medication in a shared and informed manner and will be able to liaise with GPs over any possible medication changes.

13. High risk patients (i.e. suicidal ideations, severe self injurious behaviour, psychotic symptomology) identified through clinical judgement and/or objective risk outcome tools should be urgently referred to the appropriate CMHT or mental health provider, and the referring agent informed without delay.

- **Access standard – same day**

### **General Service Principles**

14. Services need to have a particularly close relationship with Primary Care with much treatment occurring in GP practices. Close relationships with Job Centre Plus, Occupational Health services, Specialist Mental Health Services and the third sector are also required and other social support advisers as appropriate.

15. Although most patients will be referred by GPs, access should include the possibility of self-referral and referral from other statutory and third sector agencies. This will enable services to develop better access to services for sections of the community who may find it more difficult to access services via primary care, such as black and minority ethnic (BME) patients.

16. Services should ensure that access by people with common mental health problems is unhindered by complex patient opt-in or confirmation systems. Services should make strenuous efforts to assertively contact both new referrals and those patients for whom the service has lost contact during a treatment episode.
17. Services will be available to people of all ages on the basis of need.
18. Clinical eligibility will be defined on the basis of either a clinical assessment process provided by appropriately trained clinicians or a screening process provided by staff working under the supervision of appropriately trained clinicians.
19. Services will routinely collect the outcome data and provide reports specified in the IAPT Outcome Framework and Data Collection document (see [www.mhchoice.csip.org.uk/Pathfinders/Resources](http://www.mhchoice.csip.org.uk/Pathfinders/Resources)). This Framework provides recommended minimum data set (MDS) measurement tools to support the development of appropriate referral, assessment and treatment clinical protocols and reporting.
20. Wherever a new service is offered patients will be given the opportunity to choose a worker of the same gender, ethnic or cultural background and religion on referral, where this is practical. The provider will ensure that the client has access to an interpreter if necessary.
21. All clients and referrers will be able to access the services they need easily, without reasonable delay and by the most direct route possible. Access standards are set out in the patient pathway described in the IAPT Outcome Framework (see [www.mhchoice.csip.org.uk/Pathfinders/Resources](http://www.mhchoice.csip.org.uk/Pathfinders/Resources)).
22. Patients should be given a choice about where they wish to be seen (GP practice or other location), and should also be offered flexibility in terms of appointment times and the manner in which contacts are made. Some appointments outside of office hours should be available as should the possibility of contacts on the telephone, internet and email, when appropriate.
23. Appropriate publicity for the service will be developed, distributed and updated regularly by the provider.
24. The service needs to be responsive to external evaluation and allow the necessary access to data and information when required by external reviewers.
25. The service will be available 52 weeks of the year with extended and flexible office hours
26. Services must monitor access by BME and other minority groups and ensure it is in line with local need.

### **Developing an appropriate workforce**

27. **Underpinning co-ordination and ways of working.** Collaborative care case management should be the cornerstone; patients should receive contact assertively, via telephone, text or email.

28. **Supervision and management.** Providing management and case supervision at all levels, clinical governance and evaluation.
29. Treatments should be provided by clinicians with appropriate training in the relevant intervention.
30. Therapists must have regular (e.g. weekly) clinical supervision from a clinician who is fully trained in the relevant intervention.
31. Therapists should be organised in teams with an overall management structure that ensures the team provides the full range of evidence based psychological interventions in order to maximize recovery rates (e.g., individual and group therapy, cCBT, and guided self-help).

### Education, Training and Development

32. Service commissioners rarely become involved in the commissioning of education and training (with the exception of the PCMHWs). This is usually the role of SHAs and employers. An active dialogue is therefore going to be important in local pilots.
33. Where there are existing courses for graduate workers and CBT, these should be reviewed to ensure they are fit for purpose. The IAPT workforce team will be producing exemplar curricula, in modular form, based on competences, to assist local commissioners and providers (which may include HEIs) in this review. Educators will be able to access 'train the trainers' courses through the IAPT workforce team to enable them to deliver the relevant competencies.
34. Accreditation levels for CBT training are variable nationally, although the BABCP has developed extensive standards. The IAPT workforce team is engaging them and other key stakeholders to agree accreditation levels. In 2008, Skills for Health will be producing a new national qualification framework and there will be close co-operation with them in 07/08.
35. Person centred values and psychological awareness needs to be present in the entire workforce at primary and secondary levels. This therefore needs to be factored in to a local training strategy.

### Accreditation

36. All the staff in the service are required to satisfy at entry to the service and ongoing through appraisal that they have the relevant competences, supervision arrangements and access to appropriate, work based education and training as is necessary to enable them to contract for the enhanced service.
37. The service will be responsible for ensuring that adequate training and **appropriate** case management and clinical supervision in the required therapeutic competences is provided to staff.



38. All staff will be accountable to the employing Trust/Agency, which is, in turn, accountable to the Primary Care Trust for the service provision.