

# The IAPT Pathfinders

## Achievements and Challenges

October 2008

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<b>Description</b>	The IAPT Pathfinders were 11 PCTs selected to implement stepped care psychological therapies services in 2007. They received a small amount of funding, and used service redesign to develop their services and explore any specific issues relating to offenders, children and young people, older people, people from ethnic minority groups, perinatal and people with long term conditions and veterans. This report discusses their achievements and challenges.
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# Introduction

This document explores the progress made by the IAPT Pathfinder sites, celebrating their achievements and seeking to learn from the challenges they have faced. Most of the Pathfinder sites have progressed to become part of the first year of national roll-out of the IAPT programme. Their experience in seeking to meet the needs of all sections of the community, collecting effective outcomes data, and successfully implementing new services will be particularly valuable to other PCTs involved in this roll-out.

## 1.1 Pathfinder PCTs

In summer 2007, the Secretary of State for Health invited PCTs across England to submit expressions of interest in joining the Improving Access to Psychological Therapies (IAPT) programme as Pathfinder pilot sites<sup>1</sup>.

The response was immense: 70% of PCTs expressed an interest in becoming IAPT Pathfinders and half made full applications. By July 2007, 10 had been chosen<sup>2</sup> – one in each of the Strategic Health Authorities (SHAs) in England – to receive Department of Health funding. The Department of Children, Schools and Families funded an additional site to focus on children and young people.

The Pathfinder programme aimed to discover how IAPT services could in future meet the needs of the whole population by expanding the model of care, previously piloted in Newham and Doncaster, where the focus had been on adults of working age.

The Pathfinder sites were asked to address the needs of particular groups in the population – older people, children and young people, offenders, new mothers, black and minority ethnic communities, people with long-term conditions or medically unexplained symptoms. As well as delivering the core service, Pathfinders aimed to identify positive benefits and address specific barriers to improving access to psychological therapies for particular sections of the community relevant to their local population. These sections of the community were collectively described as Special Interest Groups (SIGs).

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1 <http://nds.coi.gov.uk/environment/fullDetail.asp?ReleaseID=283541&NewsAreaID=2&NavigatedFromDepartment=False>

2 <http://nds.coi.gov.uk/environment/fullDetail.asp?ReleaseID=303898&NewsAreaID=2&NavigatedFromDepartment=False>

Each received up to £200,000 to use service redesign techniques to develop:

- A defined care pathway
- A service specification including a special interest group focus
- Routine outcome monitoring using the IAPT Minimum Data Set 2007/8 (see Annex B)

The 11 Pathfinder sites were selected through rigorous regional and national processes that assessed their ability to deliver the:

- **Right numbers**
  - more patients treated, based on local needs assessment and gap analysis of current provision
- **Right services**
  - evidence-based services provided by appropriately trained and qualified staff with effective clinical, managerial and strategic leadership skills
- **Right time**
  - effective patient flow process and improved waiting times
- **Right results**
  - collecting the IAPT minimum data set for all patients at every session to measure health and wellbeing gains, including better social inclusion, employment status, choice and patient experience

During the pilot phase, the Pathfinders submitted monthly project management reports and service activity data using a nationally commissioned data collection and case management system (PC-MIS).

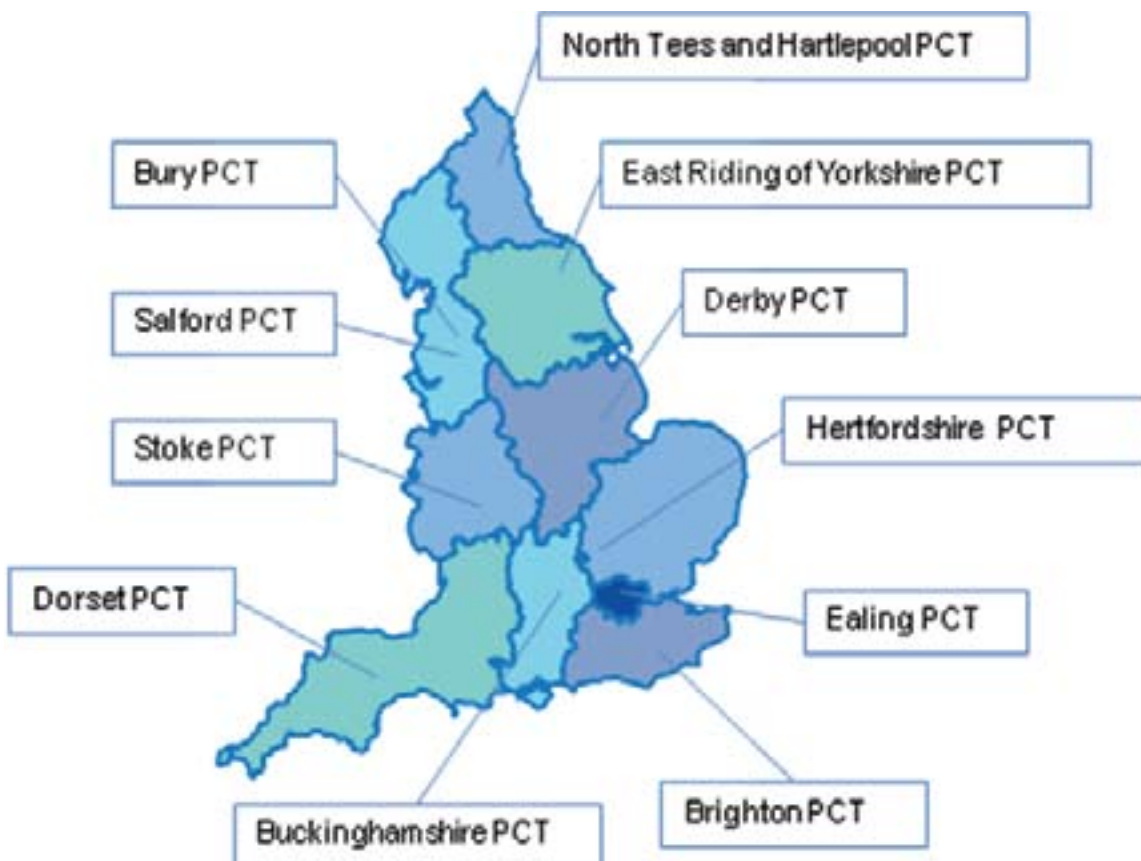
The Pathfinder site in Bury focused specifically on children and young people. A minimum data set appropriate for this age group was developed and implemented in the Bury Pathfinder. The data set was different to that used by the other sites and was not collected via PC-MIS. As such, it is not included in this analysis and evaluation, which focuses on the national picture provided by the Pathfinder sites.

For more information on the data set, service models, pathways and special interests of Bury and the other Pathfinder sites, please see the *Commissioning IAPT for the Whole Community* document and supporting Positive Practice Guides. In addition, as Pathfinders complete their own local

evaluations of the project these will be placed on the website [www.nhs.uk/iapt](http://www.nhs.uk/iapt).

A map showing the location of the 11 selected sites is provided in Figure 1 below.

**Figure 1: Location of Pathfinder Sites**



# Key Findings

The Pathfinder sites achieved a great deal in a short time with limited resources. In particular, they saw an impressive number of patients, delivered stepped care services according to NICE guidelines and demonstrated recovery rates in line with best practice.

They have also highlighted some key challenges for the IAPT programme as it enters the national roll-out phase, in particular in extending referral routes including self-referral, improving completeness of ethnicity and disability data and improving outcome management so recovery data is complete and reliable.

To address these challenges, the IAPT programme team will be developing an implementation support package that will include tools and further guidance on

- the role of primary care
- providing information for people accessing services
- the IAPT service model and clinical protocols
- data quality and completeness

## 2.1 Access to services

Although Pathfinder sites stated that they accepted referrals from many routes, GPs were the main (>90%) route of access. A reason for low rates of self-referral may be fears that services would be overwhelmed if self-referral was widely publicised. However, there is no evidence from sites that have taken this approach that it opens floodgates of demand.

Engagement with primary health teams was seen as essential to develop care pathways and referral protocols, as was training for these staff to develop knowledge of services and leadership skills.

Pathfinder sites carried out strategic needs assessments of their populations. This gave a profile of the local population who might access services, but poor monitoring of areas such as ethnicity, sexuality and disability meant that services did not know if the profile of people accessing services matched the full range of needs of their local population.

## 2.2 Interventions

Pathfinders commissioned a range of providers to supply a choice of NICE-approved interventions via multiple delivery methods. Stepped care was successfully delivered following NICE guidelines in all cases.

Pathfinders found that offering this range of interventions and modalities of delivery required staff to have clear case management skills, with systems to manage the interface between steps of care, particularly where these were delivered by different organisations.

## 2.3 Patient Experience

Overall satisfaction with Pathfinder services was high with more than 95% of people who completed questionnaires reporting a good experience of the service, the treatment and their therapist.

The average waiting time for an initial assessment and the start of treatment was 35 days in total. National best practice suggested an access standard of 7-10 working days but Pathfinders typically reported patients asking for more time to consider treatment options and to access flexible appointments.

## 2.4 Outcomes

The clinical outcomes of people seen by Pathfinder services were broadly in line with NICE guidelines and best practice from the Demonstration Sites and other services, with 49% of people who completed treatment no longer having a clinical diagnosis of depression or anxiety. The Pathfinder sites supported people back to work from sick pay and benefits at slightly higher rates (16%) than the Demonstration Sites. All patients reported improvements in wellbeing, with the biggest gains reported amongst people with more severe conditions.

Some Pathfinders achieved the required 90% complete data, but on average only 55% of those ending treatment in a planned way have complete recorded scores on clinical outcome measures PHQ9 and GAD7. Those Pathfinders who achieved the target 90% complete data did so by ensuring that some measures were monitored at every session, so that the patient's level of recovery was known even if treatment ended in an unplanned way. This is now a policy requirement for IAPT sites as the programme is rolled-out nationally.

## 2.5 Conclusions

The Pathfinders have provided tangible evidence of what the NHS can achieve to develop services that are capable of overturning the years of unmet need for people who have never before been able to rely on the NHS to help them move towards recovery. These achievements are particularly timely as the NHS begins the process of rolling IAPT services out across England from autumn 2008.

## 2.6 Recommendations

Key recommendations arising from evaluation of the Pathfinder pilot sites are that IAPT services should focus on:

- Reforming access to services
- Strengthening needs-based commissioning
- Improving outcome management

The Planning Framework 2009/10 provides guidance to SHAs on the next stage of national roll-out and also summarises the implementation support package (referred to above) that the programme will make available to all IAPT sites to help them implement these recommendations.

## 3. Access to services

More than 11,800 people were referred to IAPT Pathfinder services between October 2007 and August 2008. This represents a significant first step in demonstrating the need for these services, and beginning to meet this need. All Pathfinder services will need to expand significantly as part of national roll-out to increase the referrals they receive and target unmet need in their populations.

Of the 11,800 referrals to Pathfinders, proportions completing treatment, dropping out and found unsuitable for treatment were similar to those found by the Demonstration Sites and in line with best practice:

- More than 3,800 (32%) completed treatment
- 5,700 (48%) were still in treatment
- Nearly 1,600 (13%) dropped out of treatment
- Just over 750 (6%) were found not suitable for treatment

The national programme will provide further tools to support effective demand and capacity modelling throughout the care pathway from referral to completion and follow-up<sup>3</sup>.

### 3.1 Source of Referral

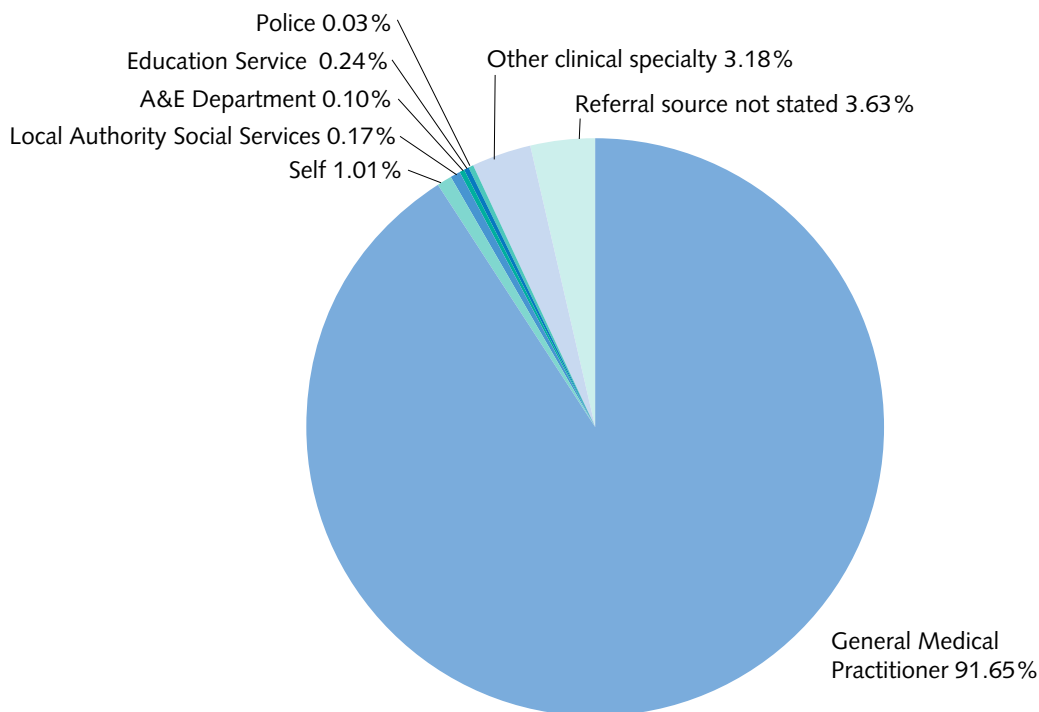
Although Pathfinder sites stated that they accepted referrals from many routes, GPs were the main (>90%) route of access. For PCTs joining the national roll-out of IAPT it will be important to increase access via self-referral and employers, as the Demonstration Sites indicated these were essential in removing barriers to access and for certain parts of the community<sup>4</sup>.

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3 Available in early 2009 at [www.iapt.nhs.uk](http://www.iapt.nhs.uk)

4 [www.iapt.nhs.uk/2008/09/publication-improving-access-to-psychological-therapy-initial-evaluation-of-the-two-demonstration-sites-by-david-m-clark-richard-layard-and-rachel-smithies-lse-centre-for-economic-performance-wor/](http://www.iapt.nhs.uk/2008/09/publication-improving-access-to-psychological-therapy-initial-evaluation-of-the-two-demonstration-sites-by-david-m-clark-richard-layard-and-rachel-smithies-lse-centre-for-economic-performance-wor/)

**Figure 2: Routes of referral to IAPT Pathfinder services**



A reason for low rates of self-referral may be fears, reported by some clinicians, that services would be overwhelmed if self-referral was widely publicised. However, there is no evidence from sites that have taken this approach that it opens floodgates of demand. More often, referrals were lower than expected and the challenge was to increase throughput by reaching out to all sections of the local community.

Pathfinder sites that did have higher rates of self-referral facilitated this by promoting a contact number for the service. Sometimes this was an existing service such as NHS Direct or a local Mental Health Helpline.

Pathfinders found that monitoring referral information such as source of referral and referring diagnosis helped them to plan appropriate care pathways and service capacity.

The *Commissioning for the Whole Community*<sup>5</sup> publication includes guidance on removing barriers to access for all groups in the community.

5 <http://www.iapt.nhs.uk/special-interests/>

## 3.2 Primary Care Engagement

All the Pathfinder sites engaged their delivery and potential delivery staff in planning how to implement the services. They also consulted GPs and Practice Based Commissioning (PBC) clusters about the referral and care pathways they were developing.

Many Pathfinder sites found it useful to provide training to delivery staff and primary care staff, covering the aims of the service, referral routes, care pathways and how the new services were to be delivered. Pathfinders worked with general practices to promote and maintain awareness of IAPT services, giving them up-to-date signposting information. Additional training needs in primary care included how to recognise common mental health problems and successfully refer people to the IAPT service.

Although there was evidence of skilled leadership in some sites, nominated lead GPs, practitioners or commissioners with a special interest in mental health sometimes needed more support in developing clinical leadership skills. A Masters course was commissioned nationally and attended by clinical leaders from all sites<sup>6</sup>. The course covered how to implement therapies in primary care, as well as commissioning and leadership. Feedback suggested that participants valued the opportunities the course gave them to develop operational and strategic thinking, and to clarify their role and that of primary care in delivery of IAPT.

As part of the implementation support package for 2009/10, further guidance will be issued on what leadership training is available across the country to support GPs to take on a “champion” role.

## 3.3 Demographic Profile

Pathfinder sites were required to collect demographic details such as age, gender, sexuality and disability to enable services to monitor and take action as necessary to ensure that all sections of the community identified in local health needs assessments were able to access services.

Very poor rates of data collection were seen in ethnicity, sexuality and disability monitoring. Ethnicity and disability information was not recorded for 39% of referrals, despite a legal duty to monitor this. This poor monitoring may have been due to workers not asking people to complete these questions, or people choosing not to give this information.

Where some groups were under-represented in referrals, mechanisms need to be introduced to engage directly with groups at high risk of common mental health problems. These groups include new mothers, older people,

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<sup>6</sup> More information available at [www.primhe.org](http://www.primhe.org)

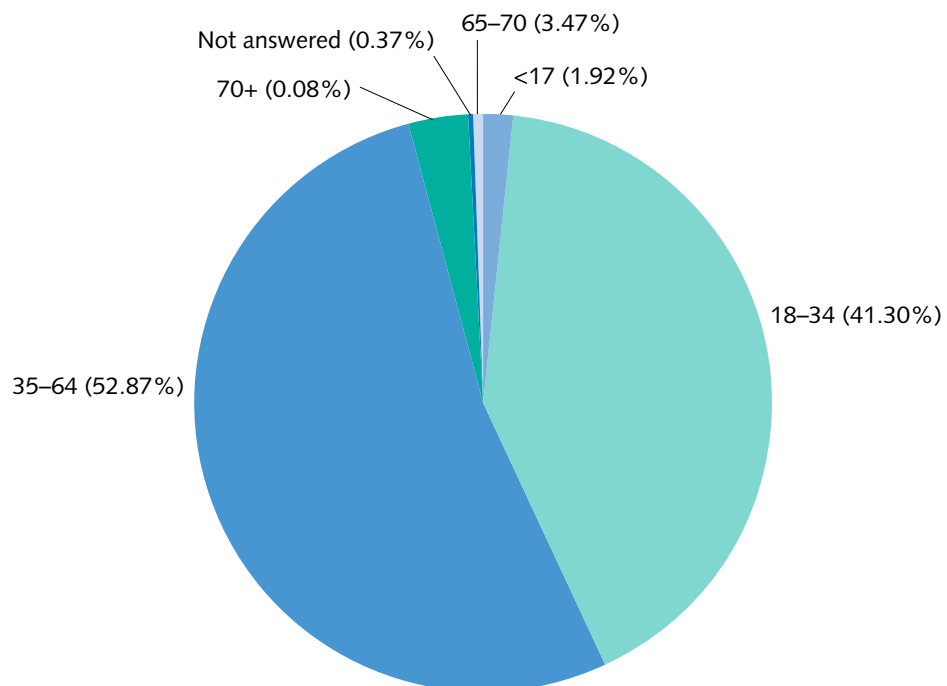
children and young people, offenders, black and minority ethnic groups. Further guidance on this is offered in the IAPT publication *Commissioning for the Whole Community*<sup>7</sup>, which builds on learning from the Pathfinder special interest groups in these areas.

### 3.3.1 Age and Gender

Almost all the referrals were adults of working age and more than half the referrals were aged 35-64. Almost two thirds of the referrals to Pathfinders were women. This distribution is broadly in line with the prevalence of common mental health problems reported nationally<sup>8</sup>.

Age and gender was monitored in nearly all (more than 99%) of referrals to the Pathfinder sites.

**Figure 3: Age profile of people accessing Pathfinder services**



### 3.3.2 Ethnicity, Sexuality and Disability

52% of all referrals were recorded as British. A total of 25 different first languages were noted from 20% of referrals. Ethnicity data cannot be matched with Office of National Statistics (ONS) data as the local populations of Pathfinders were not selected to be representative of the

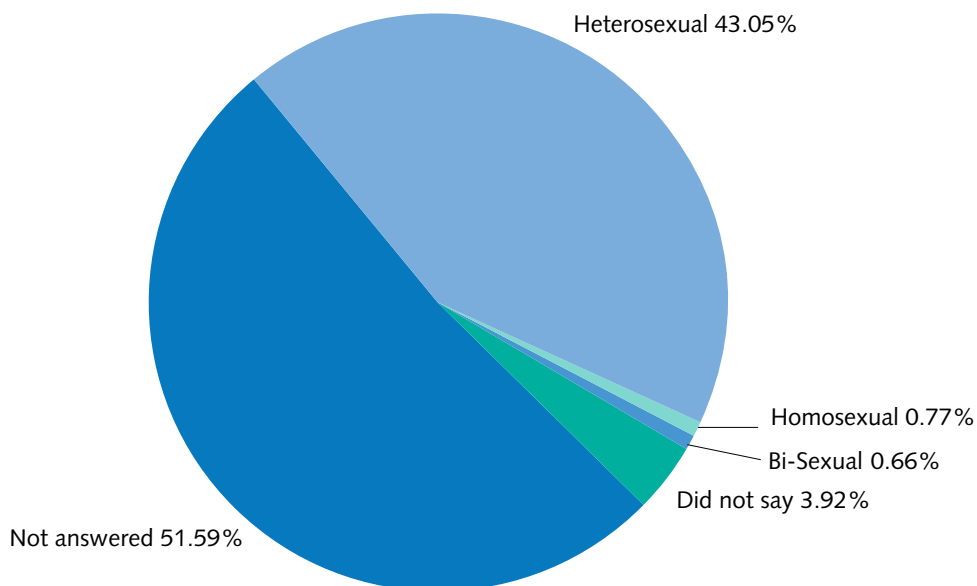
7 <http://www.iapt.nhs.uk/special-interests/>

8 Psychiatric Morbidity Survey (2000), p23-25

national population. It is therefore impossible to say whether Pathfinders as a whole enabled equal access by all sectors of the community.

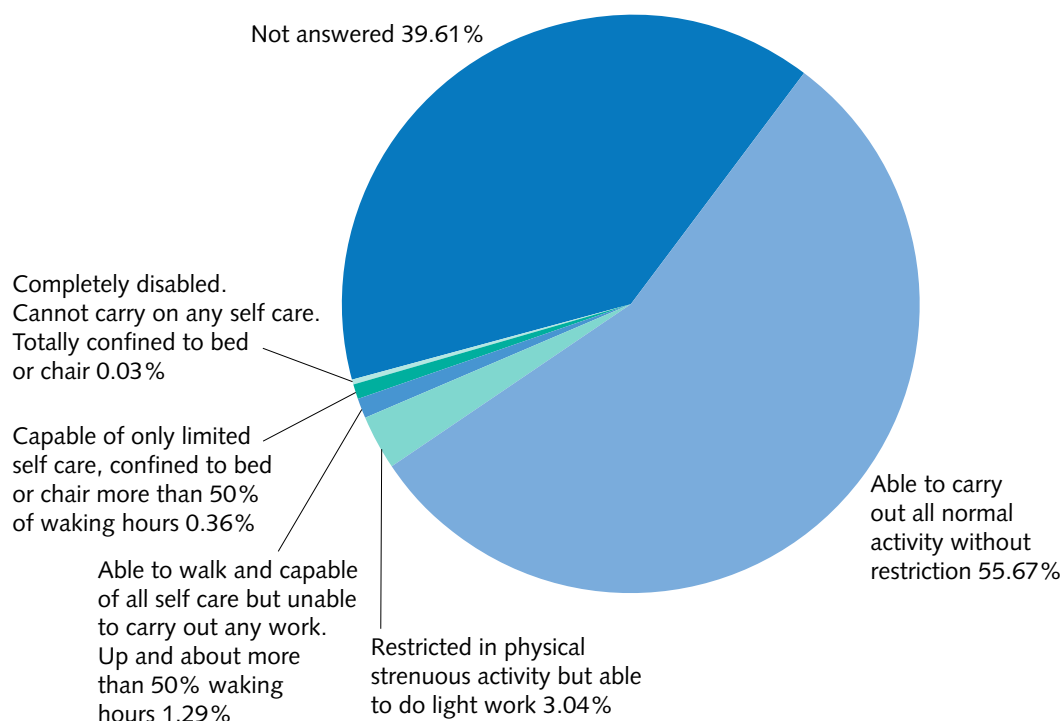
Ethnicity was not recorded for 39% of referrals, despite the legal duty to monitor this. Similarly, sexuality and disability status were very poorly recorded. It is unclear whether this is due to staff not requesting this information, or people not wishing to disclose it. Further guidance on demographic monitoring will be provided in 2009<sup>9</sup>.

**Figure 4: Sexuality profile of people accessing Pathfinder services**



<sup>9</sup> This guidance will be available on [www.iapt.nhs.uk](http://www.iapt.nhs.uk)

**Figure 5: Disability profile of people accessing Pathfinder services**



### 3.4 Presenting problem

Pathfinders felt that effective monitoring of presenting problems was important to ensure that services were meeting the assessed needs of the population<sup>10</sup>. Diagnoses came from a range of sources, including referral letters from GPs, patients' own assessment of their presenting issues or clinician assessment. However, in over a quarter of cases, no primary diagnosis was recorded.

Nearly a third (32%) of people accessing Pathfinder services presented with depression, almost one in five (17%) presented with generalised anxiety, and one in six with mixed anxiety and depression.

<sup>10</sup> Local need can be assessed using a worksheet developed by the North East Mental Health Observatory, and a query developed by St George's Healthcare NHS Trust, which extracts Read Codes from Primary Care systems (<http://www.iapt.nhs.uk/2008/08/improving-access-to-psychological-therapies-key-performance-indicators-and-technical-guidance-2008>)

**Table 1: Pathfinder referrals presented by diagnosis**

<b>Primary Presenting Problem prior to clinical assessment</b>	
Agoraphobia	0.15%
Agoraphobia with Panic	0.71%
Bereavement	2.20%
Bipolar	0.19%
Children Wellbeing	0.52%
<b>Depression</b>	<b>31.79%</b>
Drug Alcohol	0.72%
Eating Problems	0.57%
<b>Generalised Anxiety</b>	<b>17.23%</b>
<b>Mixed Anxiety &amp; Depression</b>	<b>15.41%</b>
Obsessive Compulsive	1.41%
Post Traumatic Stress Disorder	1.29%
Psychosis	0.10%
Social Phobia	0.59%
Somatisation	0.19%
Specific Phobia	0.72%
(blank)	26.20%
	100%

Although Pathfinders treated many people with depression and generalised anxiety disorder, very few patients with other anxiety disorders including PTSD, panic disorder and social phobia were treated. These problems occur in the community at approximately the same rate as generalised anxiety disorder (and are less likely to be subject to natural recovery). CBT is effective across the full range of anxiety disorders and the national curriculum for high intensity trainees provides detailed training for each of them. It is therefore important that IAPT services in the future are open to people with any of the anxiety disorders and/or depression.

For 2009/10, a Clinical Advisory Group made up of clinical leads from IAPT sites across the country will provide further clarification of the best practice IAPT service model and clinical protocols.

### 3.5 Severity and duration of problem

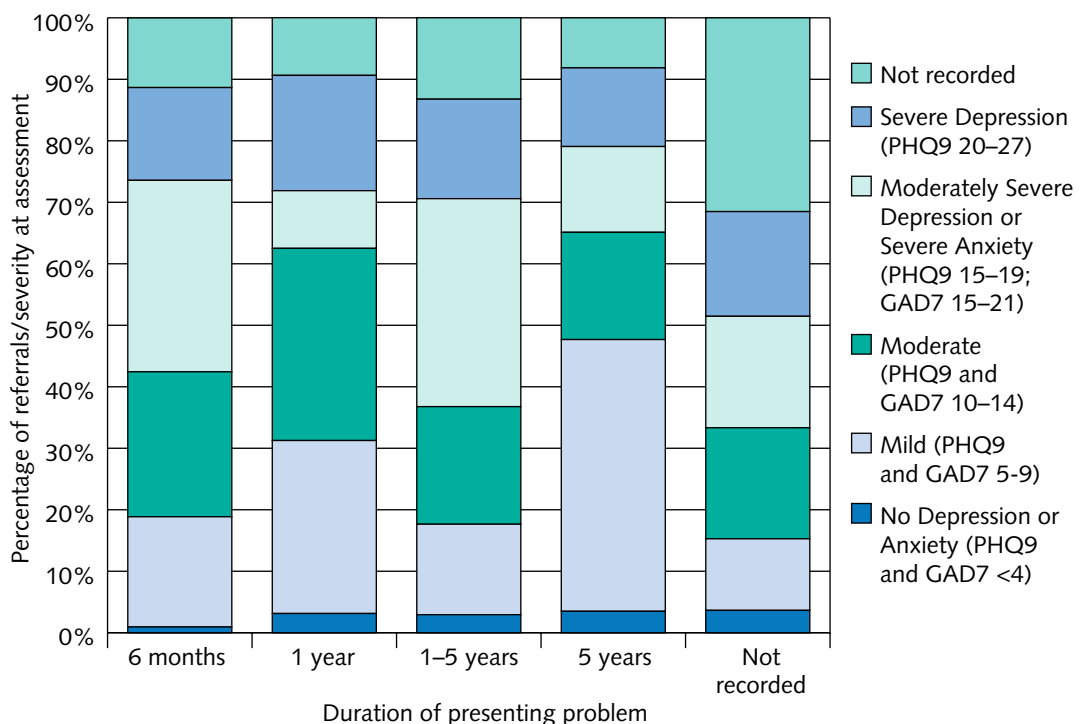
Pathfinders used the PHQ9 to measure severity of depression and GAD7 to measure severity of anxiety, administering these measures at assessment and at each therapeutic session thereafter. Duration of condition was also recorded, as reported by the patient or from GP notes.

Understanding the severity of the condition is essential in order to offer the appropriate level of intervention. Understanding the duration of the condition is important because evidence suggests spontaneous recovery is likely in up to 20% of cases within 6 months. Some services will not offer high intensity therapy until the duration of the condition is more than 6 months.

However, in more than a third of referrals for both anxiety disorders and depression, Pathfinders recorded neither the condition duration nor the clinical severity. Service managers suggest that standard referral mechanisms might assist in this process.

People referred to the service had severe, moderately severe, moderate or mild conditions in similar proportions, regardless of how long they had had their depression or anxiety disorder, as Figure 8 shows. Most referrals involved people who had had their condition for more than six months. Just under half had been unwell for more than a year and 20-25% for more than five years.

**Figure 6: Duration of episode**



# 4. Interventions

Pathfinders commissioned a range of providers to supply a choice of NICE-approved interventions via multiple delivery methods. Stepped care was successfully delivered following NICE guidelines in all cases.

Commissioned providers included statutory, independent and third sector organisations. A number of them worked together in networks delivering psychological therapy services and taking collaborative approaches to developing common access standards and delivery frameworks. They were monitored via service level agreements by commissioners.

Services aimed to provide clear and accessible information about the service and treatments available and to offer opportunities for meaningful patient feedback. Arrangements included telephone information lines, websites and patient information leaflets.

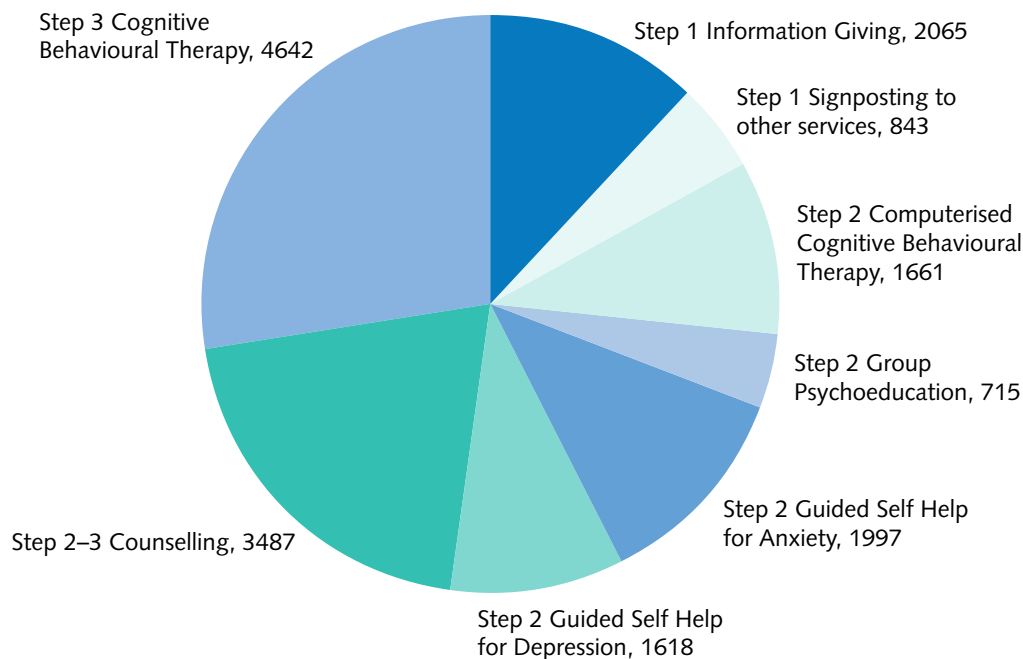
Patient Experience Questionnaire responses suggested that in some cases patients were confused by the range of options available and found it hard to make an informed choice about their treatment.

As part of the implementation support package for 2009/10, the national programme will be making recommendations for providing appropriate information to people accessing services and those who support them.

## 4.1 Range of Interventions

Figure 9 shows the range of treatments offered by Pathfinders. All of them are approved by the National Institute for Health and Clinical Excellence (NICE) based on evidence from clinical trials for treating depression or anxiety disorders, in accordance with the national programme specification.

**Figure 7: Types of treatment offered by Pathfinders**



Most people accessing services received Step 2 treatments such as Guided Self Help or Group Psycho-educational sessions. A large number of people receiving interventions at Step 2 had only one session because the initial intervention left them feeling confident to continue unsupported.

Pathfinders found that offering this range of interventions and modalities of delivery required staff to have clear case management skills, with systems to manage the interface between steps of care, particularly where these may be delivered by different organisations.

#### 4.2 Range of Delivery Methods

Pathfinders offered a flexible range of approaches in addition to face-to-face contacts. These included email, phone calls and text messaging.

Community settings were found to be highly suitable for delivering face-to-face treatments and Computerised Cognitive Behavioural Therapy has been successfully delivered in libraries.

Patients asked for appointment times and ways of receiving treatment that fitted with other commitments in their lives. For example, telephone contacts allowed people to take calls on their lunch breaks.

Signposting service users to alternative sources of support to help maintain recovery was important. 18% of people completing the Patient Experience Questionnaire said they had been offered this.

# 5. Patient Experience

Pathfinders used a Patient Experience Questionnaire to obtain direct feedback on their services from the people who used them. Overall satisfaction with Pathfinder services was high among those who completed the questionnaires, with more than 95% reporting that they were mostly or very satisfied with the service, the treatment and their therapist.

The first Patient Experience Questionnaire (PEQ1) was administered once a person came for assessment. It asks how satisfied they were with the waiting time, the choice of therapy on offer, whether they were given choice of therapy worker and what factors, such as location or time, influenced the choices they made.

The second Patient Experience Questionnaire (PEQ2) was administered at the planned end of their treatment and asks about their overall experience of the service and various aspects of it. Because this questionnaire is administered at the planned end of treatment, it does not capture the views of those patients who drop out in an unscheduled ending.

## 5.1 Waiting times

Analysis of aggregated Pathfinder data shows the average waiting time for an initial assessment and the start of treatment was 35 days in total, including 10 non-working (weekend) days.

National documents suggested best practice of 7-10 working days from referral to first treatment session but Pathfinders typically reported patients asking for more time to consider treatment options and to access flexible appointments.

This is supported by analysis of responses to Patient Experience Questionnaires where less than 10% of patients were dissatisfied with the amount of time they had to wait for an appointment.

## 5.2 Choice

People valued time to make choices relating to their therapy and Pathfinders felt it was worth giving patients longer to think about these decisions. Responses to the Patient Experience Questionnaire showed that 68% of patients felt they had insufficient time to think before they had to make important decisions. People wanted updates on the progress of their

referral and further information on the therapeutic process to help them in their decision-making.

Two-thirds of patients (66%) reported that decisions about their treatment were made with their full involvement. But a high percentage of patients said that, once they had made the decision, they did not feel they could change their mind and others said they would prefer the service to make the choice for them.

Pathfinders felt that offering patients opportunities to give feedback on the services as they are provided is likely to be a significant factor in their service experience. In line with the principles in the NHS Next Stage Review, Pathfinders were keen to ensure that results from questionnaires were integrated into service development planning and that they should have a process for dealing with specific issues arising from Patient Experience Questionnaire responses.

It can be difficult for therapists to administer questionnaires that seek feedback on patient satisfaction with the therapist, so some Pathfinders arranged for the completed forms to be left at reception.

### **5.2.1 Choice of therapy**

Pathfinders offered patients a range of interventions to support choice. However, more than 54% of people did not answer this question on the Patient Experience Questionnaire and 30% indicated they had not been offered a choice of therapy.

### **5.2.2 Choice of provider**

People had, however, been offered a choice of provider in more than a third of cases and a choice of therapist in more than half. Several factors influenced people's choice of therapy provider, including location, proximity to public transport, time of appointment and the flexibility to change appointments.

### **5.2.3 Choice of therapist**

On selecting a provider, people were offered a choice of worker in 51% of cases. At Step 3, choosing a specific worker would also choose the treatment delivered, with counsellors offering counselling and CBT therapists offering cognitive behavioural therapy, for example.

## 6. Outcomes

Pathfinder sites were asked to routinely monitor patients' conditions by collecting a range of measures pre, post and during the course of treatment. For the data to be reliable, pre and post measures needed to be available for 90% of patients, and in view of the number of unplanned ends to treatment (13%), it is imperative that data is collected every session.

Pathfinders noted the following key principles of outcome management:

- Outcome management should always be used for the benefit of patients
- Clinical measures should inform and enhance sessions, allowing the therapist and patient to discuss areas for focus of their work and to review progress in the stepped care model
- Outcomes management should provide evidence of caseloads and patient outcomes specific to clinical workers, allowing them to reflect on their practice and continue to improve clinical competence when they are working under supervision (as they do when training)
- Outcomes management should be developed, shared and agreed with stakeholders – including establishing service data sets, reporting mechanisms and performance management arrangements

### 6.1 Methods of outcome management

Pathfinders used a range of methods to manage outcomes, including paper questionnaires and direct input into computerised information systems by clinicians. Pathfinders ensured data quality by reviewing data regularly and feeding it back to individual clinicians for them to review. Pathfinders consistently recommended a named individual data lead as essential to data quality and completeness.

In some cases where Pathfinders collected data on paper forms and sent them to a central base to be entered onto a computer system, this took up to three weeks from the assessment or therapy session. This delay meant that clinicians did not have current information on their patients to inform the next stages of treatment.

## 6.2 Use of data

Some Pathfinders presented the data to key commissioning groups, who used it to discuss effectiveness of the service and to drive continuous quality improvement. Some Pathfinders publicised outcomes, which was found to increase GP interest and raise the referrals from some practices, as well as encouraging senior managers to prioritise the Pathfinder projects.

## 6.3 Data Completeness

The table below shows the range of data collected and the average rates of data completion across the 11 Pathfinder sites, indicating that they achieved very different levels of performance.

**Table 3: Pathfinders data collection rates**

Outcome Measures	Range of Rates of Data Collection for Pathfinder Site % data complete		Average Rates of Completion for Outcomes Measures %	
	Pre	Post for those with pre treatment scores	Pre	Post for those with pre treatment scores
CORE10	3%-100%	9-100%	76 %	34%
GAD7 *	80-98%	33% -95%	90%	55%
PHQ9 *	69% 98%	18%- 95%	90%	55%
WASA	35%-100%	18%-100%	32%	32%
PEQ1			85%	
PEQ2			14%	
IEQ1			50%	
IEQ2			12%	

\* Session Measure

Some Pathfinders achieved the target 95% complete data but on average, only 55% of those ending treatment in a planned way have recorded scores on clinical outcome measures PHQ9 and GAD7.

The Demonstration Sites showed that people who do not complete post-treatment measures have poorer clinical outcomes<sup>11</sup>. Therefore, recovery rates based on less than 90% complete data will over-estimate the clinical effectiveness of the service. Those Pathfinders who achieved pre and post data for 95% of patients did so by ensuring that some measures were monitored at every session, so that the patient's level of recovery was known even if treatment ended in an unplanned way.

Further information on effective outcomes management can be found in the IAPT Outcomes Toolkit 2008-0912, and a package of support to help PCTs joining national roll-out is being put in place.

## 6.4 Clinical Outcomes

The clinical outcomes of people seen by Pathfinder services were broadly in line with NICE guidelines and best practice from the Demonstration Sites and other services, with 49% of people who completed treatment no longer having a clinical diagnosis<sup>13</sup> of depression or anxiety.

On average, patients completing treatment with planned endings show significant improvement for depression and anxiety, with scores reducing from moderate depression and/or anxiety to non-clinical depression or anxiety.

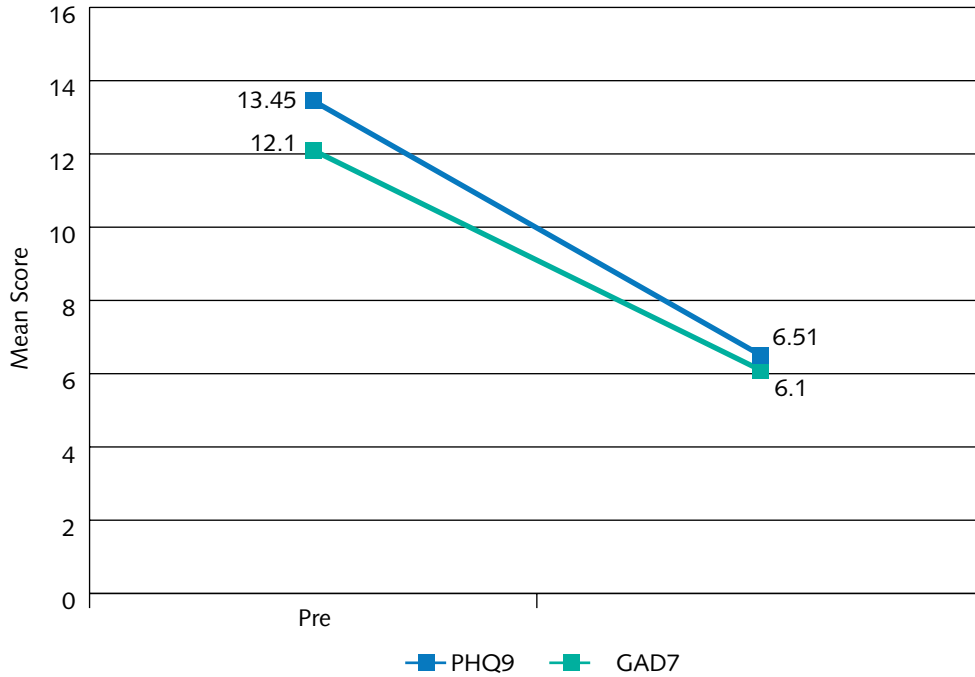
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11 Initial Evaluation of the two Demonstration Sites ([www.iapt.nhs.uk/2008/09/publication-improving-access-to-psychological-therapy-initial-evaluation-of-the-two-demonstration-sites-by-david-m-clark-richard-layard-and-rachel-smithies-lse-centre-for-economic-performance-wor/](http://www.iapt.nhs.uk/2008/09/publication-improving-access-to-psychological-therapy-initial-evaluation-of-the-two-demonstration-sites-by-david-m-clark-richard-layard-and-rachel-smithies-lse-centre-for-economic-performance-wor/))

12 <http://www.iapt.nhs.uk/2008/07/improving-access-to-psychological-therapies-iapt-outcomes-toolkit/>

13 "Non-clinical" is below caseness, defined as 9 or less on PHQ9 for depression and 7 or less on GAD7 for anxiety

**Figure 8: Improvement in clinical scores for depression (PHQ9) and anxiety (GAD7) for all patients with pre and post treatment scores including those who drop out of treatment (n=2740)**

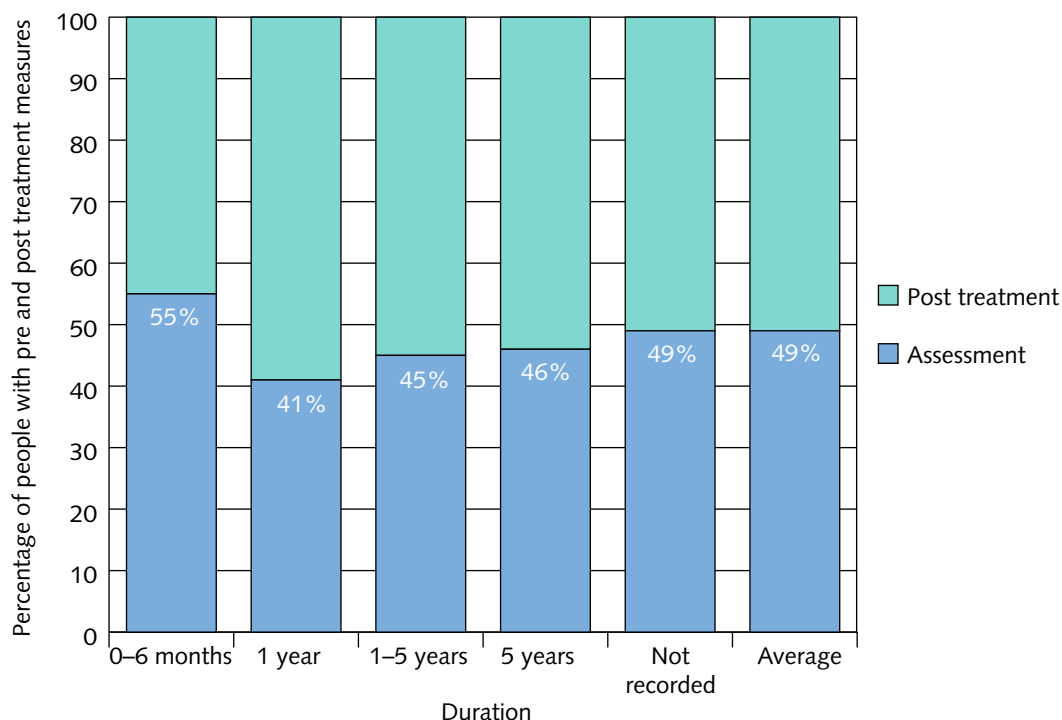


**Table 3: Improvement in clinical scores for depression (PHQ9) and anxiety (GAD7) for all patients with pre and post treatment scores including those who drop out of treatment (n=2740)**

Clinical Scores		Mean Score	N	(SD)	Effect Size
PHQ9	Assessment	13.45	2740	6.51	1.25
	Post Treatment	6.51		6.00	
GAD7	Assessment	12.10		5.41	1.11
	Post Treatment	6.10		5.28	

Figure 9 shows the percentage of patients who no longer have a diagnosis of depression or anxiety post-treatment, by duration of presenting problem at assessment.

**Figure 9: Recovery rates by duration of presenting problem for all patients with pre and post measures of anxiety and depression (n=2166) meeting clinical severity at assessment**

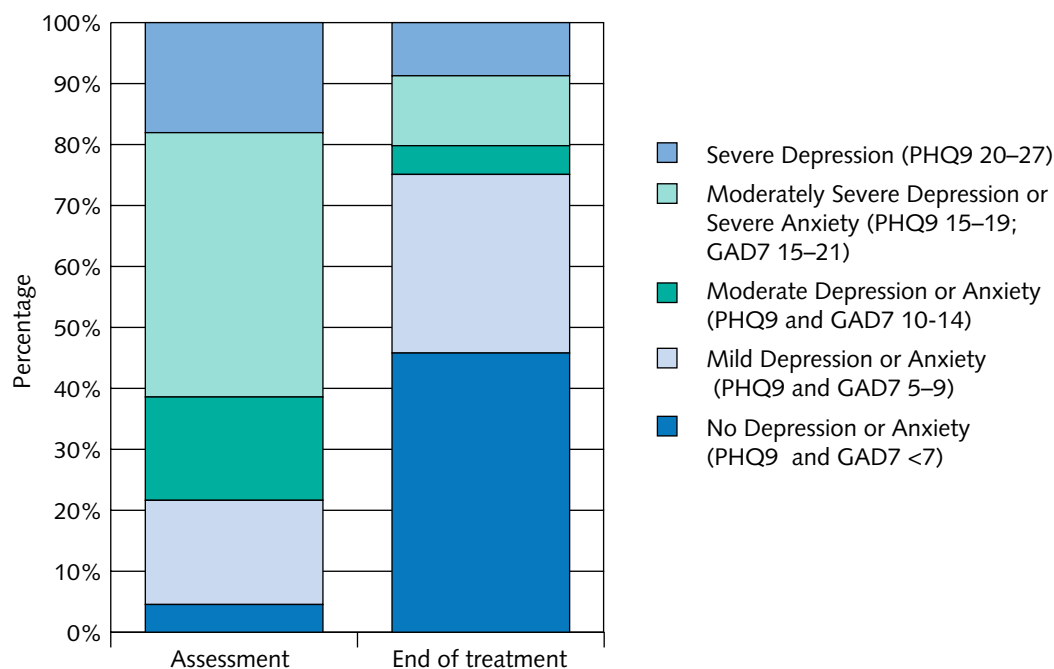


**Table 4: Recovery rates by duration of presenting problem for all patients with pre and post measures of anxiety and depression n=2166 meeting clinical severity at assessment**

Duration	No. of patients meeting clinical severity at assessment	No. of patients in recovery at the end of treatment	(%) of patients in recovery at the end of treatment
0-6 months	107	59	55
1 year	44	18	41
1-5 years	80	36	45
5 years	59	27	46
Not recorded	1876	916	49
Totals	2166	1056	49

Figure 10 shows rates of depression or anxiety severity for Pathfinder patients at discharge and compares them with their condition at assessment, using standard cut-off points on the PHQ9 and GAD7.

**Figure 10: Severity rates for depression and anxiety at post treatment compared to assessment for all patients with pre and post measures (n=2740)**



**Table 5: Severity rates for depression and anxiety at post treatment compared to assessment for all patients with pre and post measures (n=2740)**

	At assessment	Post treatment
No Depression or Anxiety (PHQ9 and GAD7 <4)	4.55%	45.80%
Mild Depression or Anxiety (PHQ9 and GAD7 5-9)	17.09%	29.30%
Moderate Depression or Anxiety (PHQ9 and GAD7 10-14)	16.95%	4.71%
Moderately Severe Depression or Severe Anxiety (PHQ9 15-19; GAD7 15-21)	43.36%	11.47%
Severe Depression (PHQ9 20-27)	18.05%	8.72%

## 6.5 Employment and Social Inclusion Outcomes

The Pathfinder sites supported people back to work from sick pay and benefits at slightly higher rates (16%) than the Demonstration Sites. This may be attributed to the close links Pathfinder sites had to local Conditions Management Programmes and other employment services, but numbers for whom complete data is available are limited so drawing general conclusions should be avoided.

In addition to the employment measures, Pathfinders also collected self-reported patient data identifying changes in their overall wellbeing. All patients reported improvements in wellbeing, with the biggest gains reported amongst people with more severe conditions.

Rates for the employment and social inclusion measures were low. These were collected at assessment and planned end of treatment. IAPT sites are now recommended to measure employment status sessionally, and to administer social inclusion measures at the penultimate session<sup>14</sup>.

Pathfinder services built on existing networks of services and agencies focused on employment in order to reduce sickness absence and potential job losses. This enhanced local collaboration between primary care, employers and agencies supporting people in employment. Examples of this included:

- Working with Job Centre Plus, who ensured patients had employment goals, gave extra support to those returning to work and facilitated engagement with their Specialist Incapacity Benefits advisor
- Integrating with existing Condition Management Programmes (CMP), who offered psycho-educational programmes to people with common mental health problems who are claiming Incapacity Benefit
- Using employment advisors to work closely with unemployed people of working age who have mild to moderate mental health problems and need support to return to or sustain mainstream vocational activity (paid employment, voluntary work or mainstream education)
- Raising awareness of mental health among local employers, including local authorities and the NHS, and offering psychosocial support in the workplace
- Linking with local employers to offer their staff direct access to Mental Health First Aid and therapy services

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14 Further information can be found in the IAPT Outcomes Toolkit 2008-09 (<http://www.iapt.nhs.uk/2008/07/improving-access-to-psychological-therapies-iapt-outcomes-toolkit/>)

### 6.5.1 Inclusion and Employment Questionnaire

The Inclusion and Employment Questionnaire (IEQ) collects and measures the change in patients' employment status and is administered at assessment and at planned end of treatment.

Table 4 shows that Pathfinders found decreases in the number of patients receiving benefits and a reduction in the average number of sick days for people who are in work (down from 4.53 to 2.60 per month). Analysis of Pre and Post Benefits Data is difficult due to low completion rates of the Inclusion and Employment Questionnaire. The average completion rate was just 12%.

**Table 6: Change in employment and benefits responses pre and post treatment**

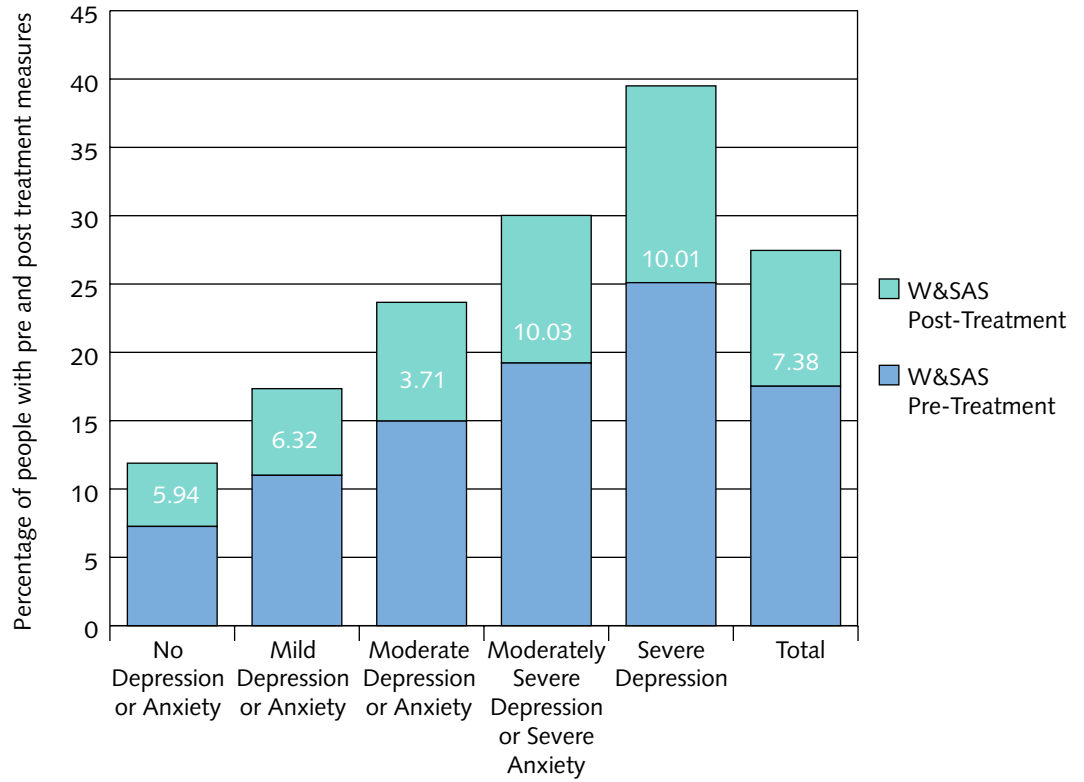
		Pre – Treatment IEQ1			
		Benefit recipient Benefit recipient (IB, IS, JSA)	Receiving Statutory Sick Pay	Employed	Total
Post Treatment IEQ2	Benefit recipient (IB, IS, JSA)	2.04%	4.08%	0.00%	6.12%
	Receiving Statutory Sick Pay	2.04%	0.00%	2.04%	4.08%
	Employed	14.29%	4.08%	71.43%	89.80%
	Total	18.37%	8.16%	73.47%	100.00%

### 6.5.2 Work and Social Adjustment Scale

The Work and Social Adjustment Scale (W&SAS) is a simple five-item measure of changes in the domains of work, home, social, private leisure and interpersonal relations. This measure examines patients who completed treatment in a planned manner. It was administered at assessment and at the planned end of treatment.

Figure 11 shows that Pathfinders found increases in W&SAS scores at all levels of severity for both anxiety and depression. Changes were greatest for those with moderately severe depression or anxiety.

**Figure 11: Change in W&SAS scores for patients stratified by initial severity of depression/ anxiety at assessment**



# 7. Conclusions

The 11 Pathfinder sites have made a substantial contribution to demonstrating the power of IAPT services in meeting the needs of people with depression and anxiety disorders. The progress they have made provides tangible evidence of what the NHS can achieve to develop services that are capable of overturning the years of unmet need for people who have never before been able to rely on the NHS to help them move towards recovery. These achievements are particularly timely as the NHS begins the process of rolling IAPT services out across England from autumn 2008.

The key successes demonstrated in this evaluation report are:

- Improved access to evidence-based psychological interventions
- Delivering health gains in line with NICE guidelines
- Spreading the benefits to the whole community
- Actively contributing to delivering broader social benefits
- Key learning points

## 7.1 Improved access to evidence based psychological interventions

Nearly 12,000 people with depression and/or anxiety disorders were referred to the IAPT Pathfinder services, with approximately 4,000 completing treatment. These numbers are an important first step and we would expect numbers to begin to rise as services mature and grow to better meet the health needs of local populations.

## 7.2 Delivering health gains in line with NICE guidelines

The Pathfinders succeeded in delivering a range of NICE-compliant psychological interventions within the IAPT stepped care service model. This provided more evidence to support the efficacy of the integrated low and high intensity services developed by the Demonstration Sites. Crucially, the Pathfinders also demonstrated a recovery rate of approximately half (49%) for patients completing treatment, in accordance with NICE expectations. The Pathfinders therefore delivered a tangible improvement in health and wellbeing outcomes for their patients.

### 7.3 Spreading the benefits to the whole community

The Pathfinders have made an important contribution to understanding the ways in which IAPT services will need to develop if they are to meet the needs of all sections of the community equally. By focusing on specific areas of need identified through local needs assessment, the Pathfinders have informed the publication of *Commissioning IAPT for the Whole Community*<sup>15</sup>, which provides positive practice guides to PCTs as part of the national roll out of IAPT.

### 7.4 Actively contributing to delivering broader social benefits

While meeting the NICE standards in terms of health gain is critical, it is also important that IAPT services are able to contribute to wider social benefits. The Pathfinders made good progress in supporting patients' employment status, with sites showing up to a 16% improvement in the employment status of patients at the completion of treatment by linking treatment to a broader set of supports designed to help people back into work.

### 7.5 Key Learning Points

In addition to the successes of the Pathfinders, there were also some important lessons to be learned from and applied to inform the national roll out of the programme. The key learning points from the Pathfinders were:

- **Referral numbers** – Referrals were not as high as expected, and certainly not nearly as high as those who were worried about unleashing a wave of unmet need onto the fledgling services. As services mature, we expect access levels to rise steadily to meet local needs assessment requirements
- **Ethnicity, sexuality and disability data** – Collection of data relating to ethnicity, sexuality and disability was poor and needs to be improved to demonstrate that service are equitable
- **GP engagement** – Pathfinders found that more effort was needed to gain clinical leadership and the support of GPs
- **Matching service capacity and demand** – Matching capacity to demand is challenging and requires a careful planned approach based on good understanding of local need and current service provision
- **Information for patients** – Patients were sometimes confused about what choices they had to make regarding the service. Clear information is essential to support equitable access and improve all patients' experience of the service

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15 <http://www.iapt.nhs.uk/special-interests/>

# 8. Recommendations

Building on the learning of the Pathfinders, several recommendations are listed below for areas where new and existing IAPT sites might focus on developing their services.

## 8.1 Reform access to services

- Develop marketing tools and patient information, with the involvement of people who access the service and those who support them in doing so
- Develop referral protocols and clear care pathways
- Strengthen the role of GPs so that referrals are made appropriately and Practice Based Commissioning ensures services meet the required demand
- Phase implementation so that, once services are in place, an effective strategy pulls referrals in

## 8.2 Strengthen needs-based commissioning

- Undertake local needs assessments which have been informed by public health data relating to mental health
- Assess the current workforce and identify gaps in provision
- Plan the increase in workforce necessary to fill the gap, considering the appropriate size and skill-mix of the service
- Take steps to encourage self referral by patients to ensure access levels rise to meet levels identified in the needs assessment
- Ensuring that demographic data about patients is collected so that it is clear if the service is addressing the needs of the whole population, regardless of age, sex, race or disability.

## 8.3 Improve outcome management

- Ensure patient data is complete for at least 90% of people seen by the services
- Build clinical ownership of outcome management by using appropriate technology to support not only data collection and reporting but also clinical service management

- Routinely monitor patient reported outcome measures as an indicator of service quality

The Planning Framework 2009/10 provides guidance to SHAs on the next stage of national roll-out and also summarises the implementation support package that the programme will make available to all IAPT sites to help them implement these recommendations.

# Annex A: PCT Pathfinder Site Profiles

<p><b>Brighton PCT</b> An urban area, population 246,900, with high levels of substance misuse, social deprivation, unemployment and housing problems. Radical redesign to offer highly accessible psychological therapy services delivered in primary care and outside mainstream mental health services.</p>	<p><b>Brighton Lesbian, Gay, Bisexual and Transgender</b> A wide range of stakeholders including people who use psychological therapy and service providers from the voluntary and statutory sectors. Mapped current provision and identified service gaps. Staff given training in this group's issues, how to address gender and sexuality in clinical consultations and new ways to provide and access services.</p>
<p><b>Buckinghamshire PCT</b> Population 479,000, relative prosperity masks pockets of extreme deprivation. Service redesign creating a joined up, stepped care pathway for adults and older adults with common mental health difficulties.</p>	<p><b>Buckinghamshire Older People</b> Sent questionnaires to Primary Care professionals examining attitudes to older people. Barriers to access examined through focus groups involving older people who have not used services.</p>
<p><b>Dorset PCT</b> Semi-rural community, population 341,338. Existing stepped care services re-designed to provide more equitable range of interventions in community settings via single point of access.</p>	<p><b>Dorset Offenders</b> Piloting the use of self-help booklets and computerized CBT in prisons. Primary care prison workers offered training in CBT techniques.</p> <p><b>Dorset Long Term Conditions</b> Practice primary care workers trained to signpost patients effectively to appropriate services, to ensure they are treated for both their long term condition and any mental health issues.</p>

<p><b>Ealing PCT</b></p> <p>Existing psychological therapies are suitable and effective in Hanwell and Central Ealing, population 103,590, but not Southall, population 64,470. Project aims to better meet the specific needs of Southall's Black and Minority Ethnic community.</p>	<p><b>Ealing Black and Minority Ethnic Community</b></p> <p>Focused on Southall's 60% Asian (Punjabi) population. Leaflets, outcomes measures and self help guides translated. Punjabi-speaking therapy workers recruited. IAPT service integrated with culturally appropriate counselling from third sector. Self-referral promoted by Punjabi/English leaflets/posters in public places, accessed via multi-lingual phone line.</p>
<p><b>East Riding of Yorkshire PCT</b></p> <p>Large region, small urban and sparse rural population including retired people with little support. Agreed psychological therapies pathways with single point of access. Workforce redesign, third sector partners engaged, local training in basic CBT extended to staff specializing in adults, older people and long-term conditions</p>	<p><b>East Riding of Yorkshire PCT Older People</b></p> <p>Developing care pathway from IAPT (steps 2 and 3 of the NICE Stepped Care model) onto steps 4 and 5 (in older people services)</p> <p><b>East Riding of Yorkshire PCT Long Term Conditions</b></p> <p>Identified related practitioners, such as community matrons, case managers etc, for training in recognising anxiety and depression and offering basic CBT techniques. Developing training programme.</p>
<p><b>North Tees and Hartlepool PCT</b></p> <p>Urban area, population 190,800, high rates of long term unemployment and incapacity. Multi-agency stakeholder partnership <i>Open Doors</i> redesigning service for communities with greatest social deprivation to increase psychosocial assessments and offer low intensity interventions.</p>	<p><b>North Tees and Hartlepool PCT Long Term Conditions</b></p> <p>Enhancing skills of GPs, Practice Nurses, Health Visitors, Community Matrons and District Nurses to address patients' psychological needs. Fast-tracking carers who need therapy.</p>
<p><b>Stoke PCT</b></p> <p>Population 237,091, the 12th most deprived local authority area in England and fourth in the North West. New primary care-based Healthy Minds Network delivering full range of psychological therapies and psychosocial interventions across the PCT. Core service, plus links to voluntary and community sector and mainstream services.</p>	<p><b>Stoke Older People</b></p> <p>Focused on mild or moderate mental health needs of people with long-term conditions and medically unexplained symptoms. Linking with mainstream NHS and social care services to aid early identification and to embed expertise.</p>

<p><b>Hertfordshire PCT</b> Semi rural area, population 1.05 million. Successful whole system service redesign delivering stepped care in Enhanced Primary Mental Health Care services. Expanding to additional sites.</p>	<p><b>Hertfordshire Long Term Conditions</b> Training staff in using outcome measures to monitor prescribing and consultation rates and unscheduled secondary care episodes.</p> <p><b>Hertfordshire Older Adults</b> Scoping exercise indicated less than 20% of expected older adults accessing services. Now mapping access to promote age inclusive services. Updating local resource packs to include services for over 65s, developing information for GP host practices to cascade to local colleagues.</p> <p><b>Hertfordshire Perinatal</b> Scoped current services, and linked with local support for expectant or new parents. Created referral pathway and guide for professionals, including specialist perinatal interventions, such as a group for pregnant and early postnatal woman with mild/moderate depression or anxiety and an infant massage group for mothers with mild to moderate depression or risk of relapse.</p>
<p><b>Salford PCT</b> Population 237,091, one of the 12 most deprived areas in England, growing ethnic minority population. Primary care therapies now beginning to embrace stepped care philosophy with high, medium and low intensity interventions and case management.</p>	<p><b>Salford Perinatal and Long Term Conditions (Diabetes)</b> Developed referral pathways and practitioner training to support pathway access for people with these conditions.</p>
<p><b>Derby City PCT</b> Inner city, population 263,000. Has largest concentration of deprivation and black and minority ethnic communities and high level of Incapacity Benefit. Maximized current interventions through employment support, including the Conditions Management Pathway in the Department for Work and Pensions' Pathways to Work programme.</p>	<p><b>Derby City Black and Minority Ethnic Community (BME)</b> Supports purposeful engagement with local community groups. Community Development Workers support innovative practice, promote joint working and facilitate access to services for people from BME communities.</p>

**Bury PCT**

Established Primary Care Mental Health Service with specialist workers for children and young people. Collaborating with third sector and Child and Adolescent Mental Health Services (CAMHS) to develop single point of entry to safe, high quality, effective talking therapies for children and young people.

**Bury Children and Young People**

Piloted tools to assess effectiveness of interventions and evaluate, adapt and, where necessary, develop new ones. Working with partners in education and other relevant services to develop tools to demonstrate impact on educational/training participation and achievement.

# Annex B: Pathfinder Care Pathway and Outcome Management

The following diagrams show the care pathway and data collection points with access standards from the IAPT Outcomes Framework 2007/8

Outcome measures from the IAPT Minimum Data Set 2007/8 represented the most suitable free-to-access tools widely used in practice as recommendations of how best to monitor outcomes relating to Health and Wellbeing, Inclusion, Choice and Access, and Patient Experience

**Figure B1: Pathfinder Care Pathway and Outcome Management**

