The Improving Access to Psychological Therapies Manual

Appendices and helpful resources

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

The Improving Access to Psychological Therapies Manual – Appendices and helpful resources

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

Contents

Appendices

Appendix A: NICE-recommended care

A.1 NICE guidance

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

- Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance (NICE clinical guideline 192)
- Common Mental Health Problems: Identification and Pathways to Care (NICE clinical guideline 123)
- Computerized Cognitive Behaviour Therapy for Depression and Anxiety (NICE technology appraisal 97)
- Depression in Adults: Recognition and Management (NICE clinical guideline 90)
- Depression in Adults with a Chronic Physical Health Problem: Recognition and Management (NICE clinical guideline 91)
- Generalised Anxiety Disorder and Panic Disorder in Adults: Management (NICE clinical guideline 113)
- Obsessive-compulsive Disorder and Body Dysmorphic Disorder: Treatment (NICE clinical guideline 31)
- Post-traumatic Stress Disorder: Management (NICE clinical guideline 26)
- Social Anxiety Disorder: Recognition, Assessment and Treatment (NICE clinical guideline 159)

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

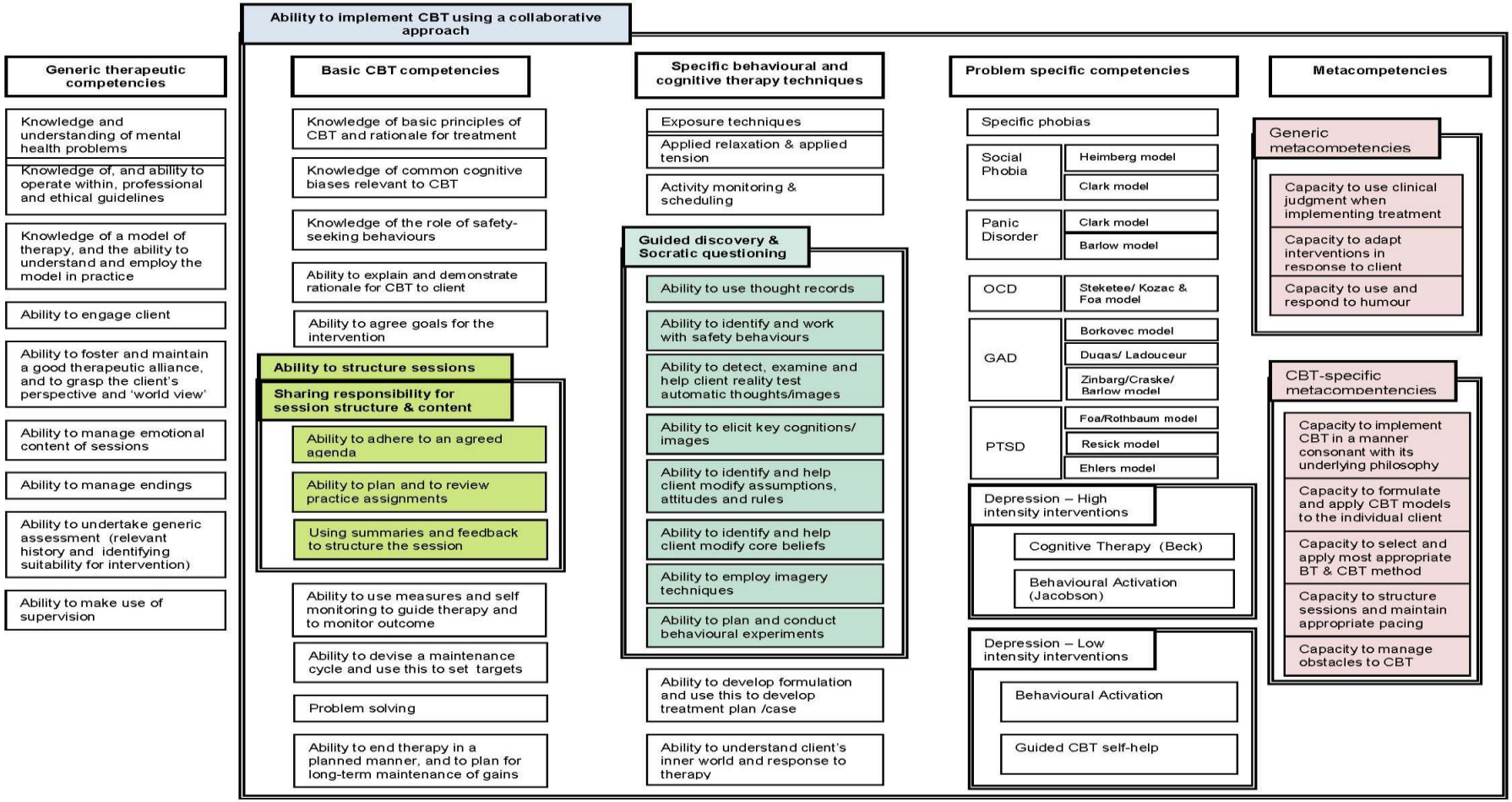
- Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (or Encephalopathy): Diagnosis and Management (NICE clinical guideline 53)
- Irritable Bowel Syndrome in Adults: Diagnosis and Management (NICE clinical guideline 61)
- Low Back Pain and Sciatica in over 16s: Assessment and Management (NICE guideline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

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

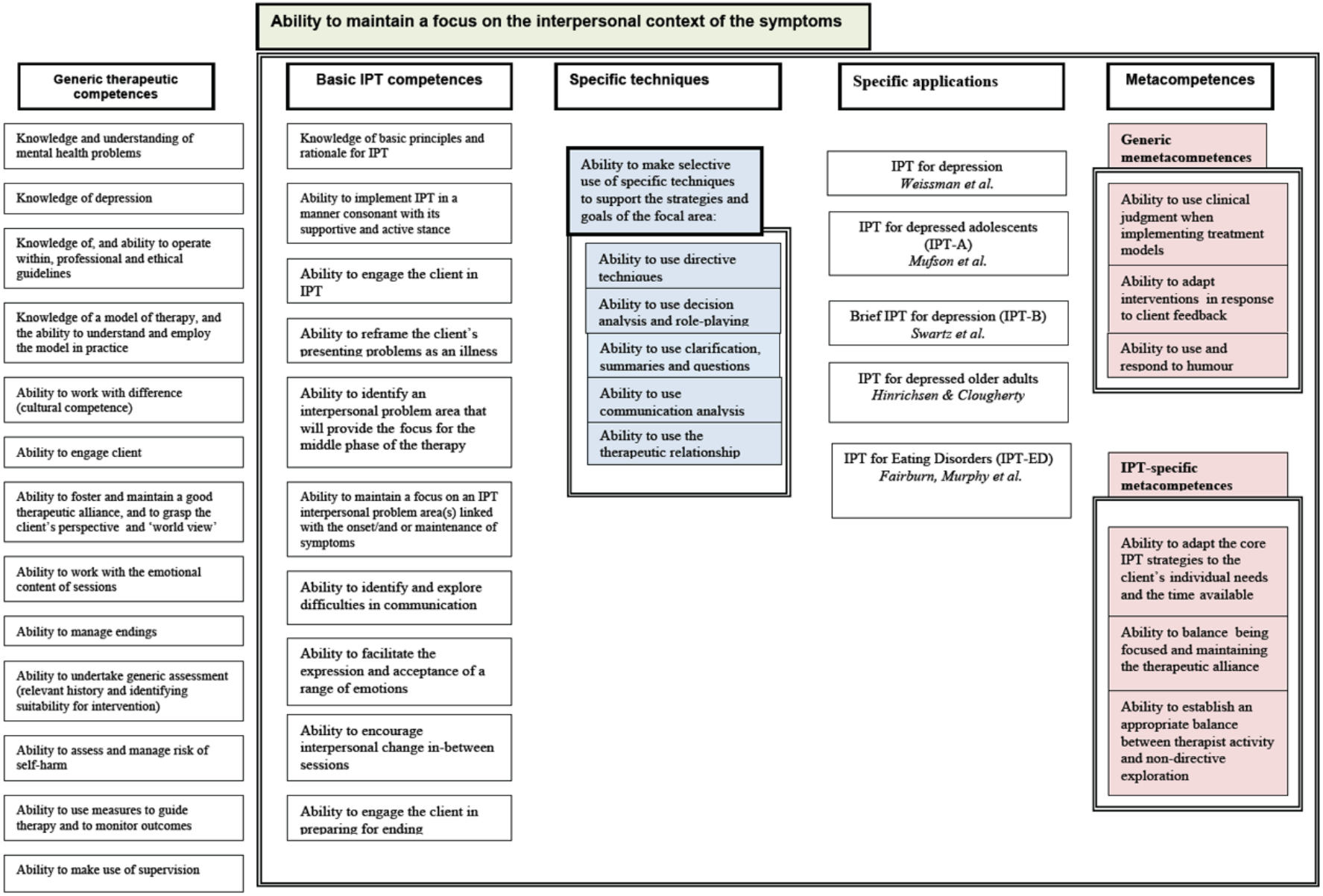
Appendix B: Competence frameworks

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

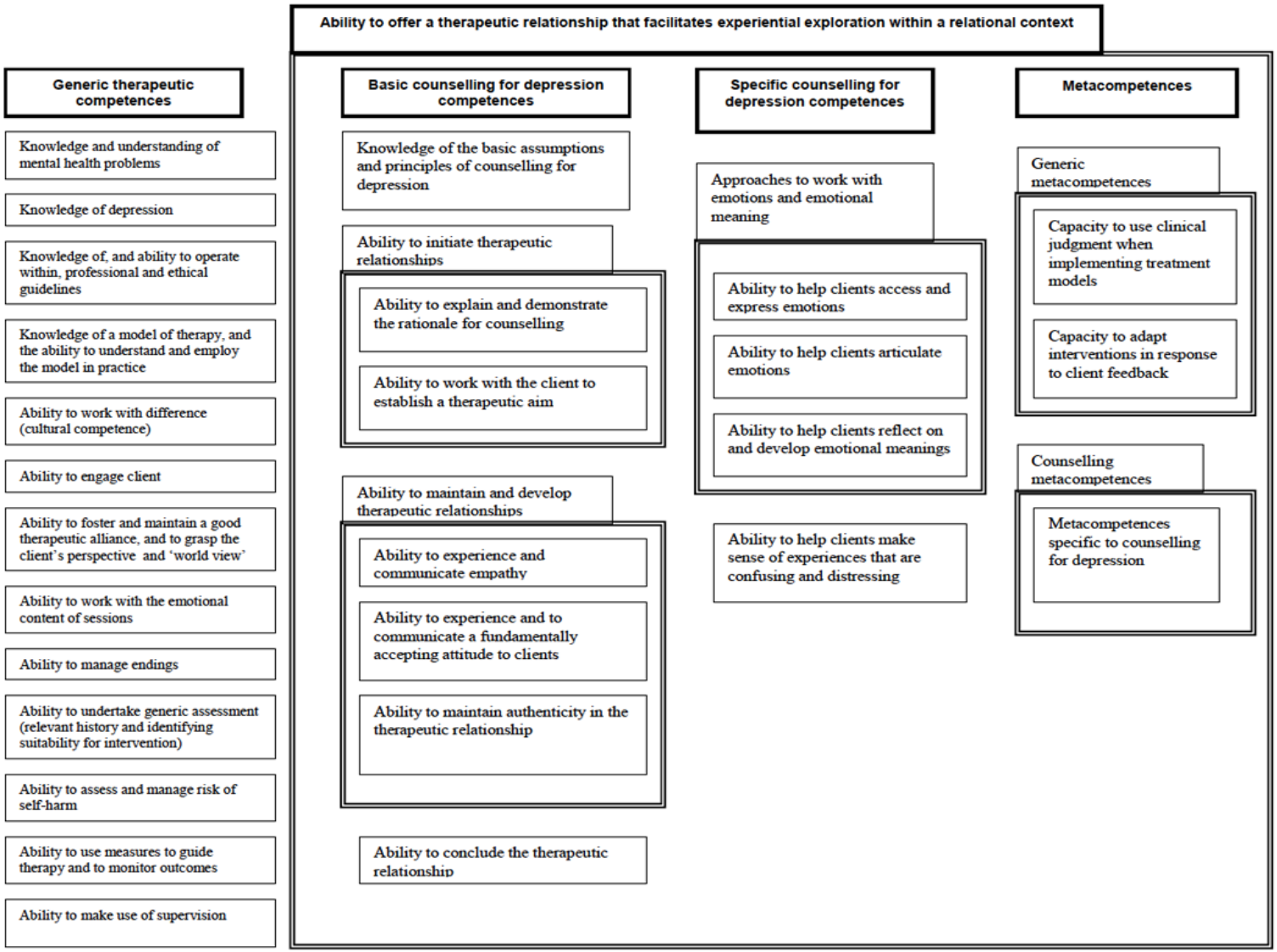
CBT competences:



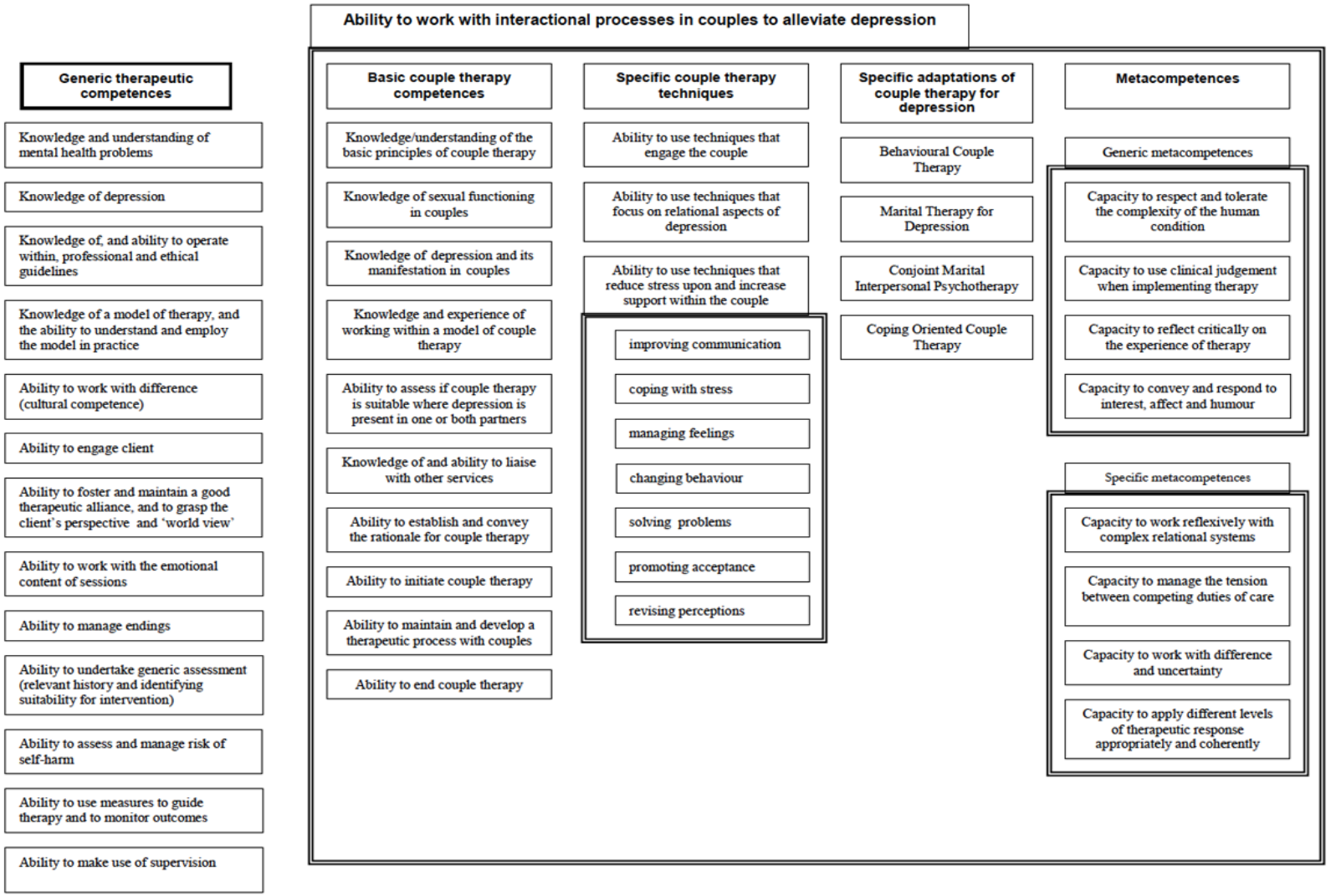
IPT competences:



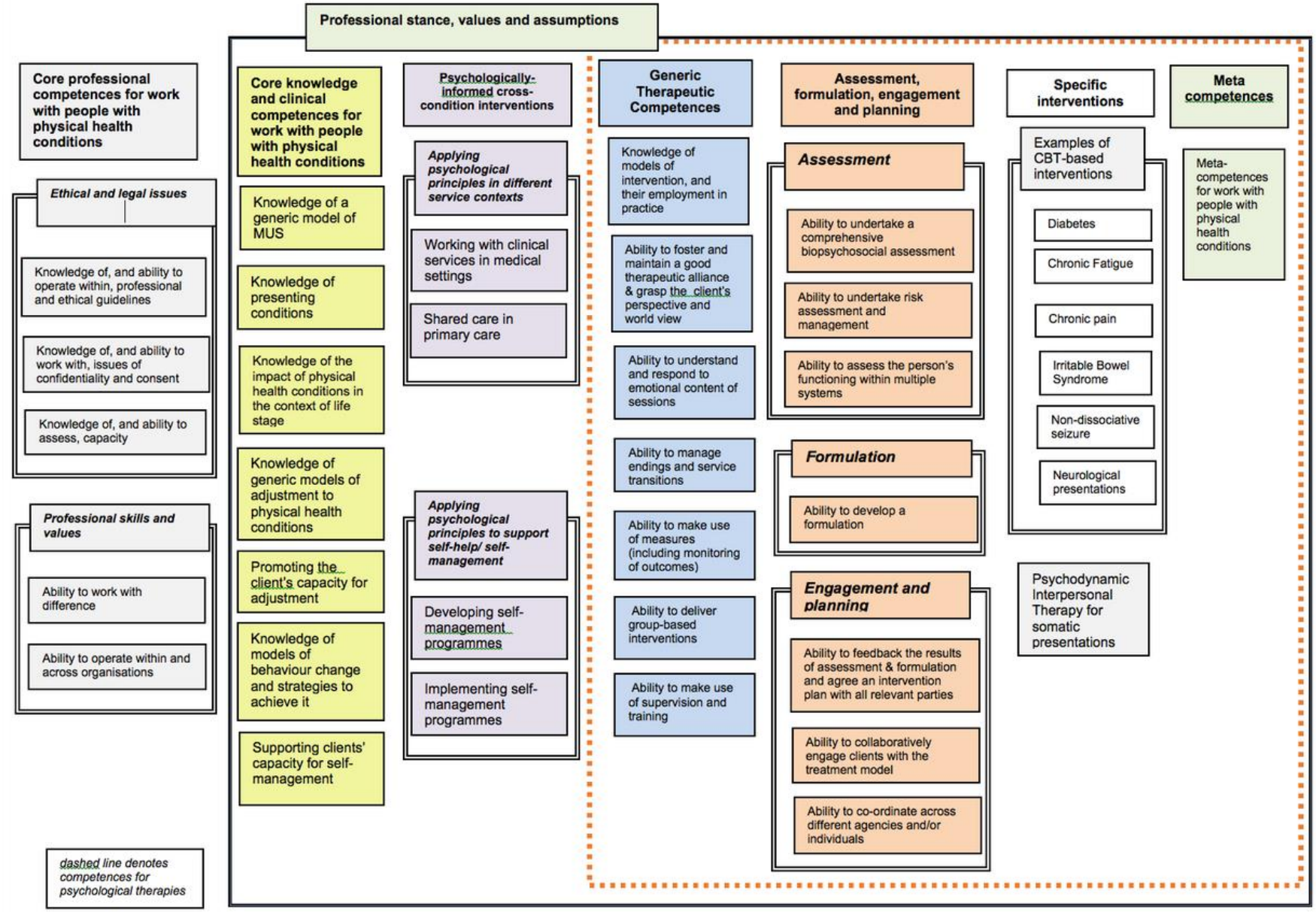
Counselling for depression competences:



Couple therapy for depression competences:

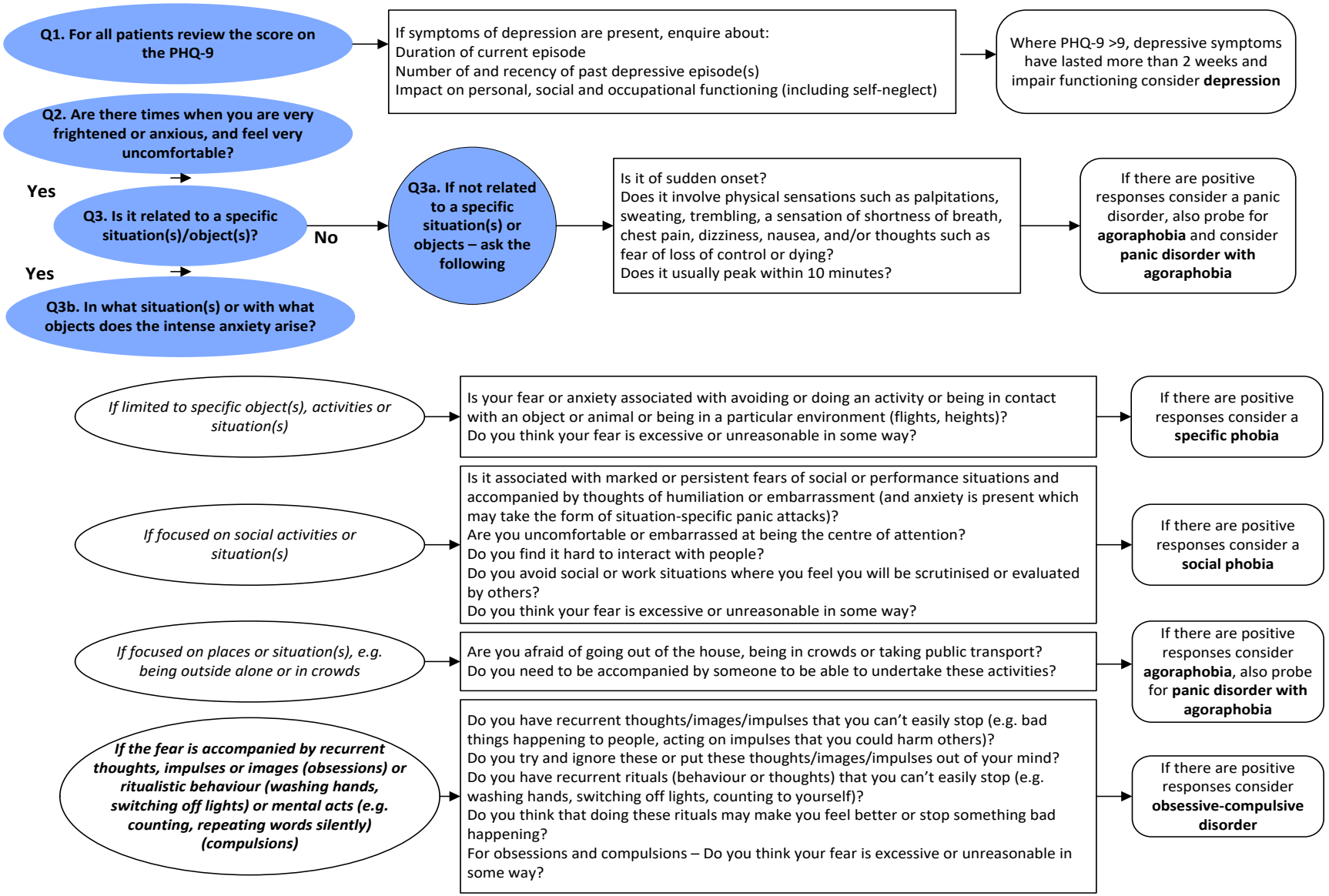


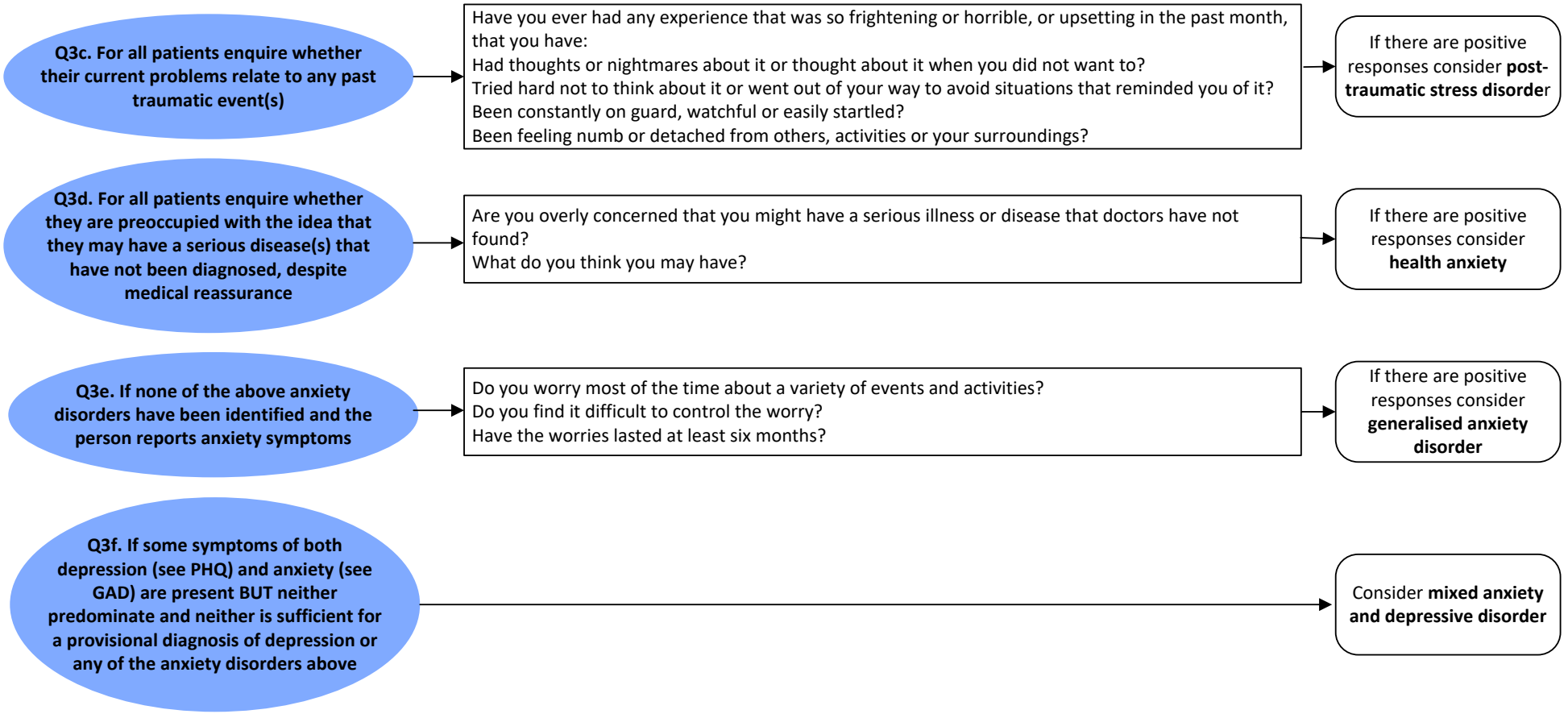
LTC/MUS competences:



Appendix C: IAPT screening prompts

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


Q1. For all patients review the score on the PHQ-9
If symptoms of depression are present, enquire about:
Duration of current episode
Number of and recency of past depressive episode(s)
Impact on personal, social and occupational functioning (including self-neglect)
Where PHQ-9 >9, depressive symptoms have lasted more than 2 weeks and impair functioning consider depression
Q2. Are there times when you are very frightened or anxious, and feel very uncomfortable?
Yes
Q3. Is it related to a specific situation(s)/object(s)?
No
Q3a. If not related to a specific situation(s) or objects – ask the following
Is it of sudden onset?
Does it involve physical sensations such as palpitations, sweating, trembling, a sensation of shortness of breath, chest pain, dizziness, nausea, and/or thoughts such as fear of loss of control or dying?
Does it usually peak within 10 minutes?
If there are positive responses consider a panic disorder, also probe for agoraphobia and consider panic disorder with agoraphobia
Yes
Q3b. In what situation(s) or with what objects does the intense anxiety arise?
If limited to specific object(s), activities or situation(s)
Is your fear or anxiety associated with avoiding or doing an activity or being in contact with an object or animal or being in a particular environment (flights, heights)?
Do you think your fear is excessive or unreasonable in some way?
If there are positive responses consider a specific phobia
If focused on social activities or situation(s)
Is it associated with marked or persistent fears of social or performance situations and accompanied by thoughts of humiliation or embarrassment (and anxiety is present which may take the form of situation-specific panic attacks)?
Are you uncomfortable or embarrassed at being the centre of attention?
Do you find it hard to interact with people?
Do you avoid social or work situations where you feel you will be scrutinised or evaluated by others?
Do you think your fear is excessive or unreasonable in some way?
If there are positive responses consider a social phobia
If focused on places or situation(s), e.g. being outside alone or in crowds
Are you afraid of going out of the house, being in crowds or taking public transport?
Do you need to be accompanied by someone to be able to undertake these activities?
If there are positive responses consider agoraphobia, also probe for panic disorder with agoraphobia
If the fear is accompanied by recurrent thoughts, impulses or images (obsessions) or ritualistic behaviour (washing hands, switching off lights) or mental acts (e.g. counting, repeating words silently) (compulsions)
Do you have recurrent thoughts/images/impulses that you can't easily stop (e.g. bad things happening to people, acting on impulses that you could harm others)?
Do you try and ignore these or put these thoughts/images/impulses out of your mind?
Do you have recurrent rituals (behaviour or thoughts) that you can't easily stop (e.g. washing hands, switching off lights, counting to yourself)?
Do you think that doing these rituals may make you feel better or stop something bad happening?
For obsessions and compulsions – Do you think your fear is excessive or unreasonable in some way?
If there are positive responses consider obsessive-compulsive disorder


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

Appendix D: Clinical cut-offs and reliable change

Table 1: Clinical cut-offs and reliable change index

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

Appendix E: Examples of patient tracking lists (PTLs)

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

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

Figure 1: Whole-service PTL showing patients still waiting for an appointment date

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

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

Figure 2: Whole-service PTL showing waits to different types of first therapy

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

Figure 3: EMDR-only PTL showing waits by different localities

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

Appendix F: Development team

F.1 NCCMH technical team

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

Tom Ayers, Senior Associate Director, NCCMH

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

Judith Chapman, Clinical Director, Berkshire Healthcare NHS Foundation Trust

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

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Kate Lorrimer, Editor, NCCMH

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Els Drewek, Head of Intensive Support, NHS England

Ursula James, IAPT Programme Manager, NHS England

Kevin Mullins, Head of Mental Health, NHS England

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

Helpful resources

1 Purpose of this resource pack

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

1.1 Positive practice examples and models

Section 2 provides positive practice examples and models from IAPT services. Further details on these services can be found on the Positive Practice in Mental Health Collaborative (PPiMH) website.

1.2 Case identification tools

Section 3 provides copies of case identification tools used in IAPT services.

1.3 Outcome measures

Section 4 provides copies of the outcome measures forms recommended for use in IAPT services and information on understanding them.

1.4 Helpful web-based resources

Section 5 contains links to helpful web-based resources, including:

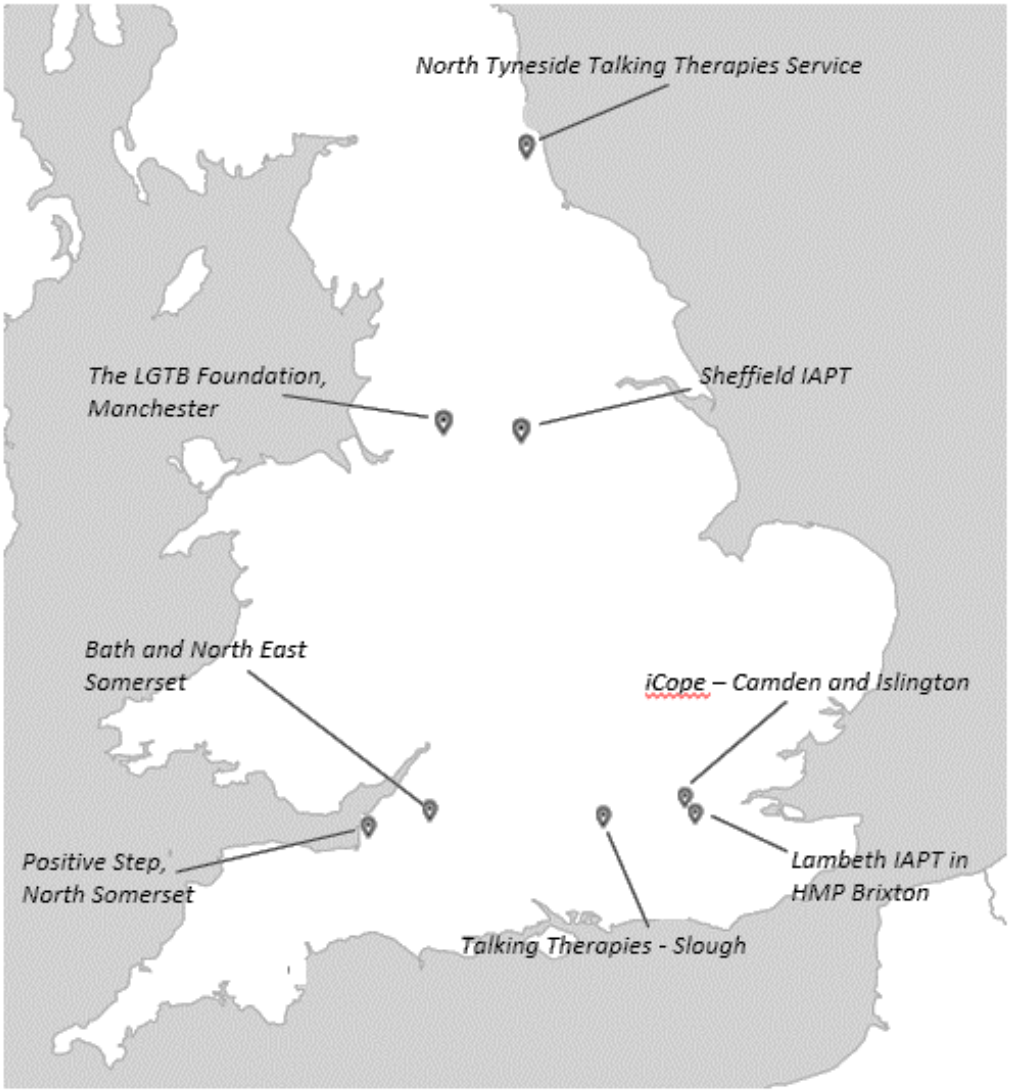
- National guidance
- Useful resources on IAPT background and context
- Useful resources on IAPT
- Useful resources on integrating physical and mental health services
- Useful organisations
- Other helpful resources

2 Positive practice examples

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

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

2.1 Map of positive practice examples for IAPT



2.2 Bath and North East Somerset

Demonstrated area(s) of positive practice

- Improving recovery:
  - data-driven reflective practice

Background

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

The approach

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

Outcomes

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

Further information

For more information contact valerieclark2@nhs.net

2.3 iCope – Camden

Demonstrated area(s) of positive practice

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

Background

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

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

The approach

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

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

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

Outcomes

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

Further information

For more information contact Dr Shimu Khamlichi. Tel: 020 33176670

PPiMH case study

2.4 iCope – Islington

Demonstrated area(s) of positive practice

- Improving recovery:
  - supportive professional learning

Background

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

The approach

Recovery consultations are a supportive professional learning environment, focused on developing the quality of therapy delivered by individual clinicians. Within the approach, it is acknowledged that a variety of factors can contribute to recovery rates. This enables open

discussion of recovery rates, and improvement via problem solving exploration and agreement on specific learning points and targets.

The service started by inviting all step 2 clinicians who had completed their training to have a 1-hour recovery consultation, at a time of their convenience, in a quiet and confidential space. This was then extended to include all step 3 workers and then any remaining clinicians identified as having lower than average recovery rates were invited.

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

Outcomes

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

Further information

For more information contact Rebecca.Minton@candi.nhs.uk

PPiMH case study

2.5 Lambeth IAPT in HMP Brixton

Demonstrated area(s) of positive practice

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

Background

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

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

The major challenges that the service faces include clinical issues such as: complexity of presentations; high prevalence of substance misuse; high prevalence of suicide and self-harm; and a higher prevalence of literacy problems. In addition, there are systemic challenges, such as: frequent security lockdowns; lack of suitable spaces for therapy; mistrust and stigma around mental health problems; security taking priority over therapy; and a high drop-out rate because prisoners often get transferred.

The approach

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

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

Outcomes

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

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

Further information

For more information contact Heather.Bolton@slam.nhs.uk

2.6 The LGBT Foundation – Manchester

Demonstrated area(s) of positive practice

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

Background

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

The approach

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

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

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

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

Outcomes

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

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

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

Further information

For more information contact
rossella.nicosia@lgbt.foundation

PPiMH case study

2.7 Positive Step – North Somerset

Demonstrated area(s) of positive practice

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

Background

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

The approach

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

Group workshops can be taken as a course or on an ad-hoc basis and are supported with handouts, audio CDs and additional information available through regular newsletters and online. These workshops are built upon the principles of CBT and organised around specific themes, aimed at building carers' resilience, including: managing stress; 'improving how you feel about yourself'; managing frustrations; 'keeping your spirits up'; and coping with change. Those who need intensive help receive one-to-one support by phone or face-to-face.

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

Outcomes

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

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

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

Further information

For more information contact Heather Dugmore. Tel: 01934 523 766.

PPiMH case study

2.8 North Tyneside Talking Therapies Service

Demonstrated area(s) of positive practice

- Reducing waiting times:
  - interim pathway

Background

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

The approach

The service combined two step 3 waiting lists. All cases were reviewed based on information given at referral, assessment and identified problem descriptors. People who presented with trauma and OCD were ruled out because it was felt that they would not benefit from a six-session therapy model. Of the 511 people waiting, 459 were identified as appropriate for the waiting list initiative. Eight (whole-time equivalent) therapists were recruited to work on the interim pathway and therapy was supported by a 6-month subscription to an online support platform (The Big White Wall). The service developed a strict missed appointment and cancellation policy, signed by both clinician and the service user. Other therapists were then able to offer people presenting with OCD or trauma a course of treatment as necessary to achieve maximum recovery results.

Outcomes

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

Further information

For more information contact Gail Richardson: gail.richardson@northumbria-healthcare.nhs.uk.

PPiMH case study

2.9 Slough Talking Therapies

Demonstrated area(s) of positive practice

- Improving equity of access and outcomes for all:
  - BAME
- Improving recovery

Background

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

The approach

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

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

- visited or phoned all GP surgeries to find out what was working and what could be improved

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

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

Outcomes

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

Further information

For more information contact Joanna Rollings: joanna.rollings@berkshire.nhs.uk

PPiMH case study

2.10 Sheffield IAPT service

Demonstrated area(s) of positive practice

- Reducing waiting times

Background

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

The approach

Sheffield IAPT undertook a number of changes, including:

- developing a new website and an online patient booking system
- providing IAPT prescription pads to support GPs
- developing data guidance and standard operating practices and data sessions delivered face-to-face within the service
- rolling out direct booking across GP practices

- developing ‘improving wellbeing’ sessions to offer a higher therapeutic dose of treatment at step 2
- improving the service’s online offering, including Skype sessions available across PWP interventions, CBT and counselling.

Outcomes

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

Further information

For more information contact Toni Mank: Toni.Mank@shsc.nhs.uk

Demonstrated area(s) of positive practice

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

Background

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

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

The approach

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

Inclusion criteria for the group is:

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

Outcomes

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

Recovery rates at the end of treatment were 46% for GAD, 0% for depression. At follow up, this rose to 70% for GAD and 33% for depression. There was no clinically significant

deterioration in GAD during the study or at follow up. The opt-in rate (87%) was comparable to rates reported in trials of individual CBT for older people with GAD. The drop-out rate (15%) was lower than previous studies of group CBT for older people with GAD.

Further information

For more information contact Heather Stonebank. Tel: 0114 2718427.

PPiMH case study

3 Case identification tools

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

GAD-2

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

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

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

3.2 Whooley questions to screen for depression

Please answer the following questions:

1. During the **past month**, have you often been bothered by feeling down, depressed or hopeless?
   ☐ YES ☐ NO
2. During the **past month**, have you often been bothered by little interest or pleasure in doing things?
   ☐ YES ☐ NO

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

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

3.3 Mini Social Phobia Inventory Scale (Mini-SPIN)

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

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

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

4 Outcome measures

4.1 Patient-reported outcome measures

The following patient-reported outcome measures are recommended for routine use in IAPT services. A copy of each outcome measure is provided below.

Table 2: Recommended outcome measures by problem descriptor

Main mental health problem (primary problem descriptor)	Depression symptom measure	Recommended measure for anxiety symptoms or MUS	Further option, only used if 'recommended measure for anxiety symptoms or MUS' is missing	Measure of disability
Depression	**PHQ-9**	**GAD-7**		WSAS
GAD	**PHQ-9**	**GAD-7**		WSAS
Mixed anxiety/depression	**PHQ-9**	**GAD-7**		WSAS
No problem descriptor	**PHQ-9**	**GAD-7**		WSAS
Social anxiety	**PHQ-9**	**SPIN**	GAD-7	WSAS
PTSD	**PHQ-9**	**PCL-5**	GAD-7	WSAS
Agoraphobia	**PHQ-9**	**MI**	GAD-7	WSAS
OCD	**PHQ-9**	**OCI**	GAD-7	WSAS
Panic disorder	**PHQ-9**	**PDSS**	GAD-7	WSAS
Body dysmorphic disorder (BDD)	**PHQ-9**	**Body Image Questionnaire**	GAD-7	WSAS
Irritable bowel syndrome (IBS)	**PHQ-9**	**Francis IBS Scale**	GAD-7	WSAS
Chronic fatigue syndrome	**PHQ-9**	**Chalder Fatigue Questionnaire**	GAD-7	WSAS
Chronic pain (in context of anxiety/depression)	**PHQ-9**	**GAD-7**		WSAS
MUS not otherwise specified	**PHQ-9**	**PHQ-15**	GAD-7	WSAS

Note: Recovery, reliable improvement and reliable deterioration rate calculations should be based on the pair of measures highlighted in bold. When the measure in bold in the third column is missing, the recovery calculation is based on the combination of PHQ-9 and GAD-7, if this is different.

Cut-off scores: PHQ-9 – 10 and above; GAD-7 – 8 and above; Obsessive-Compulsive Inventory (OCI) – 40 and above; Social Phobia Inventory (SPIN) – 19 and above; Agoraphobia-Mobility Inventory (MI) – above an item average of 2.3; PTSD Checklist for DSM-5 (PCL-5) – 32 and above; Panic Disorder Severity Scale (PDSS) – 8 and above; Body Image Questionnaire – 40 and above

4.1.1 Patient Health Questionnaire – 9 items (PHQ-9)

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

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

The PHQ-9 is also available in the following languages:

- Hindi
- Punjabi
- Bengali
- Gujurati
- Urdu.

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

Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
		GAD7 total score (Data item 38 in the IAPT Data Standard)			☐

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

4.1.3 Social Phobia Inventory (SPIN)

Social Phobia Inventory

Initials _____Age _____Sex _____Date _____ID#_____

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

	Not at all	A little bit	Somewhat	Very much	Extremely
1. I am afraid of people in authority.	0	1	2	3	4
2. I am bothered by blushing in front of people.	0	1	2	3	4
3. Parties and social events scare me.	0	1	2	3	4
4. I avoid talking to people I don't know.	0	1	2	3	4
5. Being criticized scares me a lot.	0	1	2	3	4
6. Fear of embarrassment causes me to avoid doing things or speaking to people.	0	1	2	3	4
7. Sweating in front of people causes me distress.	0	1	2	3	4
8. I avoid going to parties.	0	1	2	3	4
9. I avoid activities in which I am the center of attention.	0	1	2	3	4
10. Talking to strangers scares me.	0	1	2	3	4
11. I avoid having to give speeches.	0	1	2	3	4
12. I would do anything to avoid being criticized.	0	1	2	3	4
13. Heart palpitations bother me when I am around people.	0	1	2	3	4
14. I am afraid of doing things when people might be watching.	0	1	2	3	4
15. Being embarrassed or looking stupid are my worst fears.	0	1	2	3	4
16. I avoid speaking to anyone in authority.	0	1	2	3	4
17. Trembling or shaking in front of others is distressing to me.	0	1	2	3	4

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

4.1.4 Mobility Inventory (MI)

Appendix D9 - Agoraphobia - Mobility Inventory

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

1. Never avoid
2. Rarely avoid
3. Avoid about half the time
4. Avoid most of the time
5. Always avoid

(You may use numbers half-way between those listed when you think it is appropriate. For example, 3½ or 4½). Write your score in the blanks for each situation under both conditions; when accompanied, and, when alone. Leave blank those situations that do not apply to you.

Place	When accompanied			When alone		
Theatres						
Supermarkets						
Classrooms						
Department stores						
Restaurants						
Museums						
Elevators/lifts						
Auditoriums or stadiums						
Car parks						
High Places						
Tell How High						
Enclosed spaces (e.g. tunnels)						
Open spaces						
(A) Outside (e.g. fields, wide streets, courtyards)						
(B) Inside (e.g. large rooms, lobbies)						
RIDING IN:						
Buses						
Trains						
Undergrounds/Tubes						
Airplanes						
Boats						
Driving or riding in a car:						
(A) At any time						
(B) On motorways						
SITUATIONS:						
Standing in lines						
Crossing bridges						
Parties or social gatherings						
Walking on the street						
Staying at home alone						
Being far away from home						
Other (specify): _____						
Totals: >>>>>>>>>>>>>>>>>>>>>>>						

(Data items 40 & 41 in the IAPT Data Standard)

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

4.1.5 Obsessive-Compulsive Inventory (OCI)

Name..... Date..... initial/re-baseline/mid/end/follow up

The following statements refer to experiences which many people have in their everyday lives. Please CIRCLE the number that best describes **HOW MUCH** that experience has **DISTRESSED** or **BOTHERED YOU DURING THE PAST MONTH.**

	DISTRESS				
	Not at all	A little	Moderat -ely	A lot	Extremely
1. Unpleasant thoughts come into my mind against my will and I cannot get rid of them.	0	1	2	3	4
2. I think contact with bodily secretions (perspiration, saliva, blood, urine etc.) may contaminate my clothes or somehow harm me.	0	1	2	3	4
3. I ask people to repeat things to me several times, even though I understood them the first time.	0	1	2	3	4
4. I wash and clean obsessively.	0	1	2	3	4
5. I have to review mentally past events, conversations and actions to make sure that I didn't do something wrong.	0	1	2	3	4
6. I have saved up so many things that they get in the way.	0	1	2	3	4
7. I check things more often than necessary.	0	1	2	3	4
8. I avoid using public toilets because I am afraid of disease or contamination.	0	1	2	3	4
9. I repeatedly check doors, windows, drawers etc.	0	1	2	3	4
10. I repeatedly check gas and water taps and light switches after turning them off.	0	1	2	3	4
11. I collect things I don't need.	0	1	2	3	4
12. I have thoughts of having hurt someone without knowing it.	0	1	2	3	4
13. I have thoughts that I might want to harm myself or others.	0	1	2	3	4
14. I get upset if objects are not arranged properly.	0	1	2	3	4
15. I feel obliged to follow a particular order in dressing, undressing and washing myself.	0	1	2	3	4
16. I feel compelled to count while I am doing things.	0	1	2	3	4
17. I am afraid of impulsively doing embarrassing or harmful things.	0	1	2	3	4

4.1.6

	DISTRESS				
	Not at all	A little	Moderat -ely	A lot	Extremely
18. I need to pray to cancel bad thoughts or harmful things.	0	1	2	3	4
19. I keep on checking forms or other things I have written.	0	1	2	3	4
20. I get upset at the sight of knives, scissors and other sharp objects in case I lose control with them.	0	1	2	3	4
21. I am excessively concerned about cleanliness.	0	1	2	3	4
22. I find it difficult to touch an object when I know it has been touched by strangers or certain people.	0	1	2	3	4
23, I need things to be arranged in a particular order.	0	1	2	3	4
24. I get behind in my work because I repeat things over and over again.	0	1	2	3	4
25. I feel I have to repeat certain numbers.	0	1	2	3	4
26. After doing something carefully, I still have the impression I have not finished it.	0	1	2	3	4
27. I find it difficult to touch garbage or dirty things.	0	1	2	3	4
28. I find it difficult to control my own thoughts.	0	1	2	3	4
29. I have to do things over and over again until it feels right.	0	1	2	3	4
30. I am upset by unpleasant thoughts that come into my mind against my will.	0	1	2	3	4
31. Before going to sleep I have to do certain things in a certain way.	0	1	2	3	4
32. I go back to places to make sure that I have not harmed anyone.	0	1	2	3	4
33. I frequently get nasty thoughts and have difficulty in getting rid of them.	0	1	2	3	4
34. I avoid throwing things away because I am afraid I might need them later.	0	1	2	3	4
35. I get upset if others change the way I have arranged my things.	0	1	2	3	4
36. I feel that I must repeat certain words or phrases in my mind in order to wipe out bad thoughts, feelings or actions.	0	1	2	3	4
37. After I have done things, I have persistent doubts about whether I really did them.	0	1	2	3	4
38. I sometimes have to wash or	0	1	2	3	4

4.1.7

	DISTRESS				
	Not at all	A little	Moderat -ely	A lot	Extremely
clean myself simply because I feel contaminated.					
39. I feel that there are good numbers and bad numbers.	0	1	2	3	4
40. I repeatedly check anything which might cause a fire.	0	1	2	3	4
41. Even when I do something very carefully I feel that it is not quite right.	0	1	2	3	4
42. I wash my hands more often or longer than necessary.	0	1	2	3	4
Total (add all scores together) (Data item 45 in the IAPT Data Standard)					

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

4.1.8 Panic Disorder Severity Scale (PDSS)

Name:_____
Date:_____

Panic Disorder Severity Scale – Self Report Form

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

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

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

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

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

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

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

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

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

fear and avoidance this past week.

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

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

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

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

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

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

past week, answer how you think you would have done if you did have opportunities.)

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

Reference: Shear MK, Brown TA, Barlow DH, et al. Multicenter collaborative Panic Disorder Severity Scale. American Journal of Psychiatry. 1997; 154:1571–1575

4.1.9 PTSD Checklist for DSM-5 (PCL-5)

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

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

4.1.10 Body Image Questionnaire Weekly

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

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

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

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

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

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

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

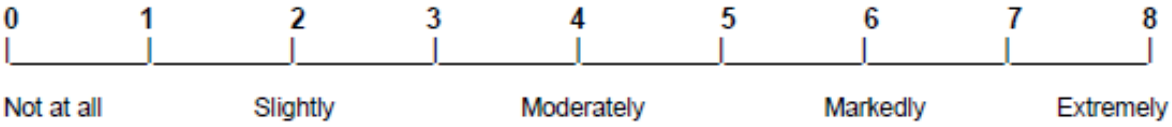
4) How often does your feature(s) **currently** lead you to avoid situations or activities?

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

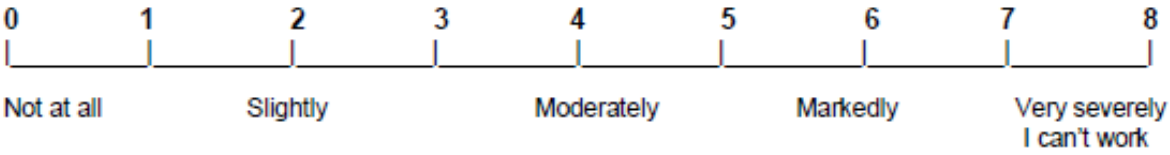
5) To what extent does your feature(s) **currently** preoccupy you? That is, you think about it a lot and it is hard to stop thinking about it?

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

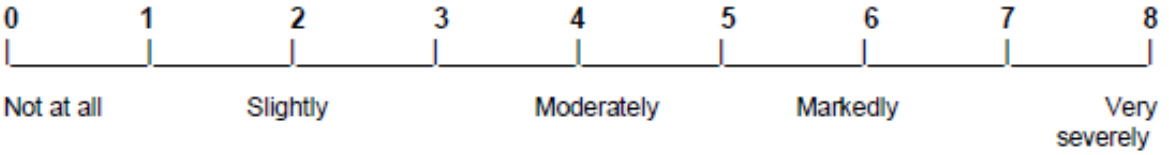
6) If you have a partner, to what extent does your feature(s) **currently** have an effect on your relationship with an existing partner? (e.g. affectionate feelings, number of arguments, enjoying activities together). If you do **not** have a partner, to what extent does your feature(s) **currently**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



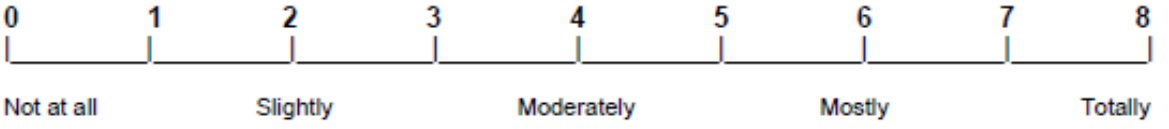
7) To what extent does your feature(s) currently interfere with your ability to work or study, or your role as a homemaker? (Please rate this even if you are not working or studying: we are interested in your ability to work or study.)



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



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



Veale, D. et al (2012).

4.1.11 Patient Health Questionnaire (Physical symptoms, PHQ-15)

PHYSICAL SYMPTOMS (PHQ-15)

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

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

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

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

4.1.12 Francis Irritable Bowel Scale

irritable bowel syndrome (ibs) severity score

1.) how severe has your has your abdominal (tummy) pain been over the last ten days?

0	1	2	3	4	5	6	7	8	9	10
no pain		*not very severe*			*quite severe*		*severe*			*very severe*

2.) on how many of the last 10 days did you get pain? _____ *number of days with pain*

3.) how severe has your abdominal distension (bloating, swollen or tight) been over the last ten days?

0	1	2	3	4	5	6	7	8	9	10
no distension		*not very severe*			*quite severe*		*severe*			*very severe*

4.) how satisfied have you been with your bowel habit (frequency, ease, etc) over the last ten days?

0	1	2	3	4	5	6	7	8	9	10
very happy			*quite happy*			*unhappy*				*very unhappy*

5.) how much has your IBS been affecting/interfering with your life in general over the last ten days?

0	1	2	3	4	5	6	7	8	9	10
not at all			*not much*			*quite a lot*				*completely*

Reference: Francis CY, Morris J, Whorwell PJ. The irritable bowel severity scoring system: a simple method of monitoring irritable bowel syndrome and its progress. Alimentary Pharmacology and Therapeutics. 1997; 11:395-402

4.1.13 The Chalder Fatigue Scale

Chalder Fatigue Scale

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

	Less than usual	No more than usual	More than usual	Much more than usual
Do you have problems with tiredness?				
Do you need more rest?				
Do you feel sleepy or drowsy?				
Do you have problems starting things?				
Do you lack energy?				
Do you have less strength in your muscles?				
Do you feel weak?				
Do you have difficulties concentrating?				
Do you make slips of the tongue when speaking?				
Do you find it more difficult to find the right word?				
	Better than usual	No worse than usual	Worse than usual	Much worse than usual
How is your memory?				

Reference: Cella M, Chalder T. Measuring fatigue in clinical and community settings. Journal of Psychosomatic Research. 2010; 69:17-22.

4.1.14 Work and Social Adjustment Scale

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems look at each section and determine on the scale provided how much your problem impairs your ability to carry out the activity.

1. **WORK** - if you are retired or choose not to have a job for reasons unrelated to your problem, please tick N/A (not applicable)

0	1	2	3	4	5	6	7	8	N/A
Not at all		Slightly		Definitely		Markedly	Very severely, I cannot work		☐

2. **HOME MANAGEMENT** – Cleaning, tidying, shopping, cooking, looking after home/children, paying bills etc

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly	Very severely	

3. **SOCIAL LEISURE ACTIVITIES -** With other people, e.g. parties, pubs, outings, entertaining etc.

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly	Very severely	

4. **PRIVATE LEISURE ACTIVITIES –** Done alone, e.g. reading, gardening, sewing, hobbies, walking etc.

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly	Very severely	

5. **FAMILY AND RELATIONSHIPS –** Form and maintain close relationships with others including the people that I live with

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly	Very severely	

total score ☐

Reference: Mundt JC, Marks IM, Shear MK, Greist JM. The Work and Social Adjustment Scale: a simple measure of impairment in functioning. The British Journal of Psychiatry. 2002;180:461-64.

4.2 Patient-reported experience measures

4.2.1 The assessment PEQ

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

To help you answer the Choice questions, the below link to WHICH talking therapy for depression? details the different psychological therapies you may be offered to treat your depression
http://tinyurl.com/WhichTherapy
Alternatively, services may have a paper copy of the document.

Please tick one box for each question

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

	SATISFACTION	Completely Satisfied	Mostly Satisfied	Niether Satisfied nor Dis-satisfied	Not Satified	Not at All Satisfied
1	How satisfied were you with your assessment	☐	☐	☐	☐	☐

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

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

4.2.2 The treatment PEQ

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

Please tick one box for each question

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

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

Thank you very much. We appreciate your help.

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

4.3 Understanding outcome measures

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

Caseness

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

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

- PHQ-9 ≥10
- GAD-7 ≥8
- Agoraphobia-Mobility Inventory ≥2.3
- Social Phobia Inventory ≥19
- Panic Disorder Severity Scale ≥8
- Obsessive-Compulsive Inventory ≥38
- PTSD Checklist for DSM-5 (PCL-5) ≥32
- Health Anxiety Inventory (Short Week) ≥18
- Body Image Questionnaire Weekly ≥40

Recovery

Patients are considered **recovered** if their scores for depression and/or anxiety are above the clinical cut-off on either measure at the start of treatment and their scores for **both** are below the clinical cut-off at the end of treatment. IAPT operates a policy of only claiming demonstrated recovery. This means that the small (less than 2%) number of patients who have missing post-treatment data are coded as not recovered.

Reliable improvement and reliable deterioration

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

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

Reliable recovery

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

5 Helpful web-based resources

5.1 National guidance

Achieving Better Access to Mental Health Services by 2020

Closing the Gap: Priorities for Essential Change in Mental Health

The Five Year Forward View for Mental Health

Implementing the Five Year Forward View for Mental Health

Five Year Forward View for Mental Health: One Year On

The Government's mandate to NHS England for 2016-17

NHS England Five Year Transformation Programme

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

5.2 Useful resources on IAPT background and context

Adult Psychiatric Morbidity Survey

5.3 Useful resources on IAPT

Description of early implementer sites (IAPT-LTC services)

Improving Access to Psychological Therapies Data Set

Improving Access to Psychological Therapies Executive Summary (October 2016)

Map to show location of wave one early implementers

Monthly Improving Access to Psychological Therapies (IAPT) Reports

NHS England: Adult Improving Access to Psychological Therapies programme

The IAPT Manual

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

5.4 Useful resources on integrating physical and mental health services

Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2:

Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison

Mental Health Services for Adults and Older Adults

Better Care Fund strategies

Bringing Together Physical and Mental Health

King's College London: Integrating mental and physical healthcare

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

Integrated Personal Commissioning Programmes

Integrated primary and acute care systems vanguards

New care models

Sustainability and Transformation Plans

NHS England value framework and logic models for IAPT-LTC

5.5 Useful organisations

British Psychological Society

Care Quality Commission

Health Education England

Mental Health Innovation Network

NHS Benchmarking

NHS Digital

NHS England

NHS Improvement

Public Health England

Royal College of General Practitioners

Royal College of Psychiatrists

5.6 Other helpful resources

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

The PWP Recruitment and Retention Best Practice Guide and PWP Code of Conduct developed by the North West PWP Professional Network with support of the North West Psychological Professions Network (PPN) can be found here.

Useful information on supporting LGBT people can be found at Transwiki – Gender Identity Research and Education Society.

Abbreviations

ADSM	Anxiety disorder specific measure
APMS	Adult Psychiatric Morbidity Survey
BAME	Black, Asian and minority ethnic
CBT	Cognitive behavioural therapy
CCG	Clinical commissioning group
COPD	Chronic obstructive pulmonary disease
CPD	Continuing professional development
CQC	Care Quality Commission
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th edition
GAD-7	Generalised Anxiety Disorder Scale – 7 items
GP	General practitioner
HMP	Her Majesty's Prison
IAPT	Improving Access to Psychological Therapies
IAPT-LTC	IAPT services for people with long-term physical health conditions and medically unexplained symptoms
IBS	Irritable bowel syndrome
IPT	Interpersonal psychotherapy
LGBT	Lesbian, gay, bisexual and transgender
LTC	Long-term physical health condition
MBCT	Mindfulness-based cognitive therapy
MDS	Minimum Data Set
MI	Agoraphobia-Mobility Inventory
MUS	Medically unexplained symptoms
NCCMH	National Collaborating Centre for Mental Health
NICE	National Institute for Health and Care Excellence
OCD	Obsessive-compulsive disorder
OCI	Obsessive-Compulsive Inventory
PCL-5	Posttraumatic Checklist
PDSS	Panic Disorder Severity Scale
PEQ	Patient Experience Questionnaire
PHQ-9	Patient Health Questionnaire – 9 items
PHQ-15	Patient Health Questionnaire – 15 items
PPiMH	Positive Practice in Mental Health Collaborative
PTSD	Post-traumatic stress disorder
PWP	Psychological wellbeing practitioner
RCT	Randomised controlled trial
SPIN	Social Phobia Inventory
UCL	University College London
WSAS	Work and Social Adjustment Scale

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