NHS Talking Therapies

NHS Talking Therapies for anxiety and depression Manual

(Formerly known as Improving Access to Psychological Therapies)

for anxiety and depression

NHS Talking Therapies for anxiety and depression Manual

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It is the responsibility of all NHS Talking Therapies workforce including trainees, to familiarise themselves with the content of this manual.

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Foreword

Depression and anxiety disorders can have a devastating effect on individuals, their families and society. Thankfully, considerable progress has been made in developing effective psychological therapies for these conditions. This progress has been recognised by the National Institute for Health and Care Excellence (NICE) which now recommends psychological therapies as first choice interventions for depression and multiple anxiety-related disorders. However, in most countries few members of the public benefit from these advances because there are insufficient appropriately trained therapists. England is an exception. Starting in 2008, the NHS has trained and employed an increasing number of clinicians who work in NHS Talking Therapies services for anxiety and depression. Individuals who are seen within those services can expect to receive a course of NICE-recommended psychological therapy from an appropriately trained and supervised individual and to have their clinical outcomes monitored and reported.

In 2023 the Improving Access to Psychological Therapies (IAPT) programme was renamed NHS Talking Therapies for anxiety and depression to facilitate public recognition and clarify the clinical conditions that are treated in the services.

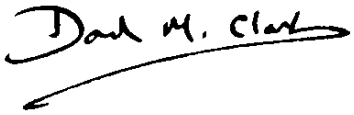
From small beginnings, NHS Talking Therapies has grown so that in 2024-25 it saw 1.21 million people. Over 670,000 went on to have a course of treatment. The others received an assessment, advice and signposting (if appropriate). A unique outcome monitoring system ensured that 99% of treated individuals had their depression and anxiety assessed at the beginning and end of treatment. One might expect attenuation of clinical outcomes when treatments are implemented outside the artificial environment of a clinical trial. However, NHS Talking Therapies set itself the ambitious target of achieving close to comparable results. Specifically, a minimum of 50% recovery for all individuals completing treatment, which was achieved for the first time in January 2017. Currently approximately one in two people who have a course of treatment in NHS Talking Therapies recover and two out of three people show worthwhile improvements in their mental health. The effort to secure such impressive outcomes has generated substantial learning which this document aims to share nationally and internationally. The success of NHS Talking Therapies has been recognised and the NHS has committed to further expanding NHS Talking Therapies services.

The NHS Talking Therapies Manual has been written to help system leaders, managers and clinicians expand their local NHS Talking Therapies services while maintaining quality and ensuring that patients receive effective and compassionately delivered care. Initially a team at the National Collaborating Centre for Mental Health carefully considered the research literature and drew on the accumulated wisdom of numerous clinicians and system leaders who have worked hard to make NHS Talking Therapies a success. Subsequent updates have been based on expert advice. Readers will find invaluable guidance on running an efficient NHS Talking Therapies service that achieves good outcomes with the individuals who receive a course of treatment and creates an innovative and supportive environment for staff as well as patients.

NHS Talking Therapies is continually evolving and improving. More than 8.5 million patients have already benefited from a course of treatment. However, much more can be learned about how to effectively deliver psychological therapies at scale. For this reason, the manual also provides guidance on how to use local and national data to better understand the strengths and limitations of a service, along with advice on developing and evaluating service innovation projects. The use of data has driven a number of improvements in access and outcomes for specific groups, which have improved the equity of the service. We need to go further to ensure truly equitable access and outcomes for all ethnicities, all age groups, and across socio-economic status. Many services are achieving good results for very diverse populations, and there is evidence that in the most diverse and deprived areas, focusing on quality of service has improved the outcomes for a wide range of patients.

Digital has been a particularly lively area of innovation. Most patients now complete outcome questionnaires on their mobile phone before sessions. Appointments can be booked online.

Online collection of background information before the initial clinical assessment frees up time for more in-depth discussion of patients' difficulties and identification of the best clinical pathway. Depending on patient preference, therapy can now be delivered with video conferencing. NICE also now recommends a range of digitally enabled therapies that are being introduced, while being carefully monitored.



Professor David M. Clark CBE, Co-Chair NHS Talking Therapies Expert Advisory Group



Dr Adrian Whittington Co-Chair NHS Talking Therapies Expert Advisory Group and National Clinical Advisor.

NHS Talking Therapies – core features for commissioning

The public promise

Adults with depression or anxiety disorders can expect:

- Timely access to a full dose of NICE-recommended therapy for the relevant condition.
- Treatment delivered by a clinician specifically trained in the relevant treatment, supported by weekly outcomes-focused supervision.
- Session-by-session outcome monitoring to track progress and guide treatment.
- Care delivered in a service that is equitable, transparent, safe and evidence-based.

Core features of a high-quality service

The service should be commissioned as specified in this Manual, with the following core features:

1. Evidence-Based Treatment for anxiety disorders and/or depression

- Person-centred initial assessment that: identifies the main problem descriptors for the conditions that will be the focus of treatment; identifies patient goals; generates a safety formulation; describes what will be involved in treatment; and generates hope.
- Only **NICE-recommended therapies** delivered at the correct intensity (stepped/stratified care).
- Digitally enabled therapies approved for use in this Manual

2. Skilled, Registered/Accredited Workforce

- Workforce mix: Approximately **35% PWPs/65% HITs**, with HIT workforce offering a choice of evidence-based modalities for anxiety disorders and/or depression.
- A workforce fully trained in the specific NICE-recommended treatments for anxiety disorders and depression.
- Mandatory registration/accreditation, CPD, and outcomes-focused weekly supervision.

3. Session-by-Session Outcome Monitoring

- Mandatory use of PHQ-9, GAD-7, WSAS and anxiety disorder-specific measures each session.
- ≥ 95% data completeness requirement.
- Used for clinical decisions, stepping, service improvement and public accountability.

4. Access & Waiting Time Standards

- 75% have first assessment within 6 weeks; 95% within 18 weeks.
- Treatment should start promptly after the first assessment and during step-up (at a minimum 75% of patients should start each course of treatment within 28 days, 95% of patients should start each course of treatment within 90 days).
- Ambition for 60% moving from assessment to a full course of treatment.
- Outcome targets for 2028/29: 53% reliable recovery, 71% reliable improvement.

5. Equity & Inclusion

- Active monitoring of access, outcomes and experience across all protected characteristics.
- Culturally competent materials, interpreters, outreach, and flexible modes of delivery.

6. Integration with the Wider System

- NHS Talking Therapies cannot meet needs for psychological therapies for conditions other than anxiety disorders or depression, or treat these conditions where a multi-disciplinary team approach is required.
- Clear pathways need to connect to primary care, community mental health, drug/alcohol services, physical healthcare pathways and the voluntary sector.
- Where NHS Talking Therapies cannot meet a need it should enable continuity of care to a more appropriate service.

7. Data-Driven Continuous Improvement

- Regular review of non-recovery cases.
- Quality-improvement methodologies embedded, including through deployment of local champions to push forward improvements in identified areas.
- Use of national dashboards and local analytics to monitor and improve outcomes, waits, flow and reduce inequalities.

8. Sustainable Workforce & Staff Wellbeing

- Clinical workforce expansion aligned with national planning, currently requiring a growth of 5-7% per year.
- Operational and support staffing and digital tools that support clinical effectiveness and productivity.
- Dedicated staff wellbeing plans, manageable caseloads, supervision as set out in the Manual, and programmed breaks.
- Clear senior clinical leadership and career development pathways.

What commissioners must ensure

Commission the Service to Deliver:

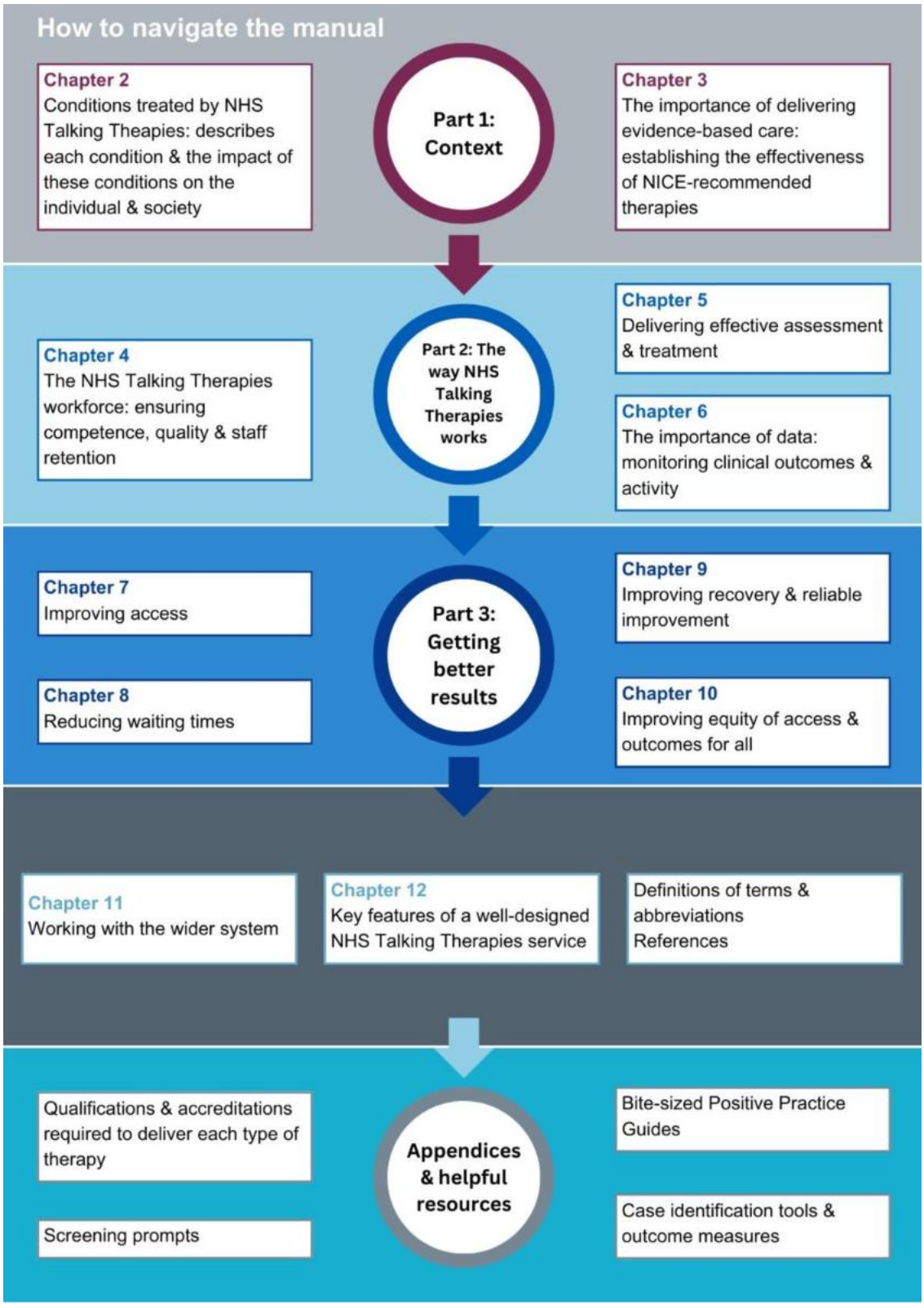
- ✓ A service as specified in this Manual
- ✓ NICE-recommended treatment only
- ✓ Prompt assessment and starting treatment / step- up
- ✓ Adequate workforce skill mix, accreditation and supervision capacity
- ✓ Session-by-session outcome monitoring
- ✓ Meeting national access and outcome standards
- ✓ Equity of access and outcomes
- ✓ Integration with wider health & care services
- ✓ Robust data quality and governance
- ✓ Sustainable, well-supported workforce

Commissioners should review contracts to consider if contract variations are required to ensure continuous alignment to national planning targets. Commissioners should seek expert advice from national and regional teams as required.

Navigating the manual

The manual has been organised into 12 chapters as set out in Figure 1, which provides a brief overview of each chapter's content.

Figure 1: How to navigate the manual



1 Introduction

The NHS Talking Therapies for anxiety and depression (formerly known as Improving Access to Psychological Therapies, IAPT) programme was developed as a systematic way to organise and improve the delivery of, and access to, evidence-based psychological therapies within the NHS. It had its roots in significant clinical and policy developments.

The success of two pilot projects established in 2006 led to the national implementation of the NHS Talking Therapies programme in 2008, which has since transformed the treatment of depression and anxiety disorders in adults in England. NHS Talking Therapies has steadily grown as a result of training and deploying over 10,000 new psychological therapists and practitioners. The Government's Autumn Statement 2023 committed to continuing funded training to expand this workforce at least until 2028/29.

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

1.1 Purpose and scope

The NHS Talking Therapies Manual serves as an essential resource for NHS Talking Therapies services. It describes the NHS Talking Therapies model in detail and how to deliver it, with a focus on the importance of providing NICE-recommended care (see Section 3). It also aims to support the further implementation and expansion of NHS Talking Therapies services.[a]

All staff involved in delivering NHS Talking Therapies for anxiety and depression services are expected to read this document. Those who manage, supervise and train the NHS Talking Therapies workforce are asked to support this by ensuring the document is shared with all colleagues, including trainees.

1.2 What are NHS Talking Therapies for anxiety and depression services?

NHS Talking Therapies services provide evidence-based treatments for people with depression and anxiety disorders. This can also be in the context of comorbid long-term physical health conditions (LTCs) or other persistent physical symptoms as well as some drug and alcohol use. NHS Talking Therapies services are characterised by three key principles – see Figure 2.

[a] The list of developers can be found in Appendix C.

Figure 2: Key principles of NHS Talking Therapies services



Services are delivered using a stepped/stratified care model, which works according to the principle that people should be offered the least intrusive intervention appropriate for their needs. Many people with less severe depression or anxiety disorders are likely to benefit from a course of low-intensity treatment delivered by a psychological wellbeing practitioner (PWP). Individuals who do not fully recover at this level should be stepped up to a course of high-intensity treatment. NICE guidance recommends that people with more severe depression and those with social anxiety disorder or post-traumatic stress disorder (PTSD) should receive high-intensity interventions from the outset.

1.3.1 Who are NHS Talking Therapies services for?

NHS Talking Therapies services provide treatment for adults with depression and anxiety disorders that can be managed effectively in a uni-professional context. NICE-recommended therapies are delivered by a single competent clinician, with or without concurrent pharmacological treatment. NHS Talking Therapies services also provide treatment for people who have long-term conditions or other persistent physical symptoms in the context of depression and anxiety disorders (see Section 11.2).

NHS Talking Therapies services provide treatment for people with the following common mental health problems (see Table 1):

- Agoraphobia
- Body dysmorphic disorder
- Depression
- Generalised anxiety disorder
- Health anxiety (hypochondriasis)
- Mixed depression and anxiety (the term for sub-syndromal depression and anxiety, rather than both depression and anxiety)
- Obsessive-compulsive disorder (OCD)
- Panic disorder
- PTSD
- Social anxiety disorder
- Specific phobias (such as heights or small animals).

Drug and alcohol misuse are not automatic exclusion criteria for accessing NHS Talking Therapies if, following assessment, it is determined that the patient would benefit from NHS Talking Therapies interventions in line with NICE guidance. However, NHS Talking Therapies does not provide specific interventions to treat drug and alcohol misuse. Where possible, NHS Talking Therapies can be delivered alongside any treatment the person is also receiving for drug and alcohol use. The level of drug or alcohol misuse should not interfere with the patient's ability to attend and engage in NHS Talking Therapy sessions. If this is not the case, the best approach for treating the individual should be agreed between NHS Talking Therapies and drug and alcohol treatment services. NICE guidelines recommend that if the individual requires detox from alcohol, then this should be carried out before other treatment begins. The person may then be treated in NHS Talking Therapies when their drug or alcohol use has stabilised, even where their drug or alcohol treatment is ongoing. This highlights the need for NHS Talking Therapies and other services, particularly drug and alcohol treatment services, to work together to develop locally agreed pathways and criteria for more specialist intervention when indicated. See the NHS Talking Therapies bite-sized positive practice guide for working with people who use drugs and alcohol.

A patient's involvement with secondary mental healthcare services should also not lead to automatic exclusion from NHS Talking Therapies services, where depression or an anxiety disorder are the primary focus for treatment. NHS Talking Therapies services are not designed to treat other mental health problems such as psychosis, bipolar disorder, 'personality disorders' or eating disorders. Where these other problems are the primary focus of treatment, or where they are currently interacting significantly with anxiety and depression, a more substantial and multi-professional package of care needs to be in place and treatment should not be offered by NHS Talking Therapies. Psychological therapy needs to be provided by clinicians trained in the specific NICE recommended treatments for these conditions (e.g., CBT for Psychosis or Mentalisation Based Treatment for Personality Disorders). Where problems with anxiety and depression are less complex, uni-professional interventions, such as those delivered within NHS Talking Therapies services, may be the most appropriate, even if concurrent pharmacological treatment is provided by primary or secondary care services.

Community mental health transformation sees the development of new ways of bringing together primary and secondary care with local communities, to support people with mental health conditions. As a key part of the system, NHS Talking Therapies plays a vital role in this transformation and is integral to true integration across mental and physical health, social care, the voluntary sector and wider services. Throughout this transformation it is important that NHS Talking Therapies services remain in line with their evidence base and

only provide support to those with depression or anxiety disorders that will benefit from the uni-professional interventions offered. See guidance to improve joint working between NHS Talking Therapies and Community Mental Health services.

Many adults with PTSD who have experienced multiple traumas, childhood traumas, or single or multiple episodes of sexual violence can be treated successfully in NHS Talking Therapies services. Some patients with PTSD will have complex PTSD (CPTSD), which means additional features may be present: problems of affect regulation, particular negative beliefs about self, and difficulties sustaining relationships. If the care of PTSD and CPTSD patients can be managed in a uni-professional context, NHS Talking Therapies is likely to be appropriate. If they require broader multi-disciplinary care, Community Mental Health or Specialist Trauma Services may be more appropriate. Patients with PTSD should not be excluded from NHS Talking Therapies services because they have experienced particular types (e.g. childhood sexual abuse) or numbers of (e.g. numerous) traumas, or because they meet the criteria for CPTSD. Clinicians should assess suitability taking into account risk assessment, need for multi-disciplinary team input and the number of traumas that result in intrusive memories, rather than on the total number of traumatic events that a patient has experienced. Experiences of forced migration should also not be an exclusion criterion for NHS Talking Therapies. Instead, services should use the criteria for PTSD and focus on the difficulties the patient is experiencing in determining whether treatment within NHS Talking Therapies is appropriate. See Treatment of Post Traumatic Stress Disorder including Complex Post Traumatic Stress Disorder: Guidance for delivery of psychological therapies.

NHS Talking Therapies services should implement the Staying safe from suicide: Best practice guidance for safety assessment, formulation and management, which builds on the NICE Guidance on Self-Harm: Assessment, management and preventing recurrence. This highlights the poor predictive value of risk screening questions, and the importance of thorough person-centred assessment and safety-planning. Risk screening answers should be taken seriously when they highlight concerns, but not taken to mean the absence of future risk when they do not.

Historic or current suicidal ideation and past suicide attempts should not automatically exclude someone from accessing the support of an NHS Talking Therapies service. It is important to remember that thoughts of suicide are often part of a patient's experience of anxiety and depression. However, where a suicide safety formulation generates immediate safety concerns, NHS Talking Therapies services may not be best placed to meet the patient's needs. For example, if there are concerns that a patient may imminently attempt to take their own life, crisis services would be more appropriate. Where immediate safety concerns come to light during treatment in NHS Talking Therapies these should not automatically lead to withdrawal of NHS Talking Therapies support. However, additional support from other services may be required. In these situations, support from more appropriate specialist services should be drawn upon and NHS Talking Therapies services should follow their risk management protocols.

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

In the 2022/23 NHS Talking Therapies annual report, patients with depression as their main problem descriptor had an average score on the Patient Health Questionnaire – 9 items

(PHQ-9) at the borderline between mild-moderate and moderate-severe[b] with not much variability between systems. This indicates that people with more severe depression are being treated across all NHS Talking Therapies services despite the common misconception that NHS Talking Therapies services are only appropriate for those with less severe depression. Treatment of people with more severe depression, when appropriate, is important because such patients are particularly likely to experience a marked reduction in disability and have their lives transformed.

1.3.2 NHS Talking Therapies service provision

NHS Talking Therapies services sit within a wider system of care which is planned for specific geographical areas by local Integrated Care Boards (ICBs). NHS Talking Therapies operates as a 'hub and spoke' model, which typically includes a central management and administration office with strong primary care and community links that enables treatment to be provided in local settings that are as easy for people to access as possible (such as GP practices, community settings and voluntary organisations). Referral pathways have been specifically developed to promote access and equality. They include:

1. self-referral
2. community or voluntary service referral
3. primary care referral
4. secondary care referral (including both mental health and physical healthcare services).

NHS Talking Therapies services need to develop strong relationships with professionals across a broad range of mental and physical healthcare pathways, as well as social care, to ensure that people with needs that are not best served by NHS Talking Therapies services, receive the necessary care and treatment in the right place.

If patients are already receiving treatment in secondary care, close liaison between secondary care services and NHS Talking therapies is expected. If the referral is initiated from secondary care (directly or by suggesting the patient self-refers) the secondary care service should still provide the NHS Talking Therapies service with their ongoing treatment and care plans.

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

2 Conditions treated by NHS Talking Therapies for anxiety and depression

2.1 Depression, anxiety disorders and other conditions covered by NHS Talking Therapies for anxiety and depression

Depression and anxiety disorders are the most common mental health problems affecting individuals (approximately 16% of the population at any one time), and society.[1] Table 1 provides a brief description of depression, the most common anxiety-related disorders and other conditions treated within NHS Talking Therapies services. It is recognised that many people experience more than one of these conditions.

Table 1: Overview of depression, anxiety disorders, and other conditions

Condition	Description
Agoraphobia	Characterised by fear or avoidance of specific situations or activities that the patient worries may trigger panic-like symptoms, or from which the patient believes escape might be difficult or embarrassing, or where help may not be available. Specific feared situations can include leaving the home, being in open or crowded places, or using public transport.
Body dysmorphic disorder	Characterised by a preoccupation with an imagined defect in one's appearance or, in the case of a slight physical anomaly, the patient's concern is markedly excessive. Time-consuming behaviours such as mirror-gazing, comparing features with those of others, excessive camouflaging tactics, and avoidance of social situations and intimacy are common, which have a significant impact on the patient's levels of distress and/or occupational and social functioning.
Chronic fatigue syndrome*	Comprises a range of symptoms that include fatigue, malaise, headaches, sleep disturbances, difficulties with concentration and muscle pain. A patient's symptoms may fluctuate in intensity and severity, and there is also great variability in the symptoms different people experience. It is characterised by debilitating fatigue that is unlike everyday fatigue and can be triggered by minimal activity. Diagnosis depends on functional impairment and the exclusion of other known causes for the symptoms.
Chronic pain	An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage. The pain persists and there is some evidence that psychological factors contribute.
Depression	Characterised by pervasive low mood, a loss of interest and enjoyment in ordinary things, and a range of associated emotional, physical, and behavioural symptoms. Depressive episodes can vary in severity, from less to more severe.
Chronic Depression	A depressive episode that has lasted more than two years.
Generalised anxiety disorder	Characterised by persistent and excessive worry (apprehensive expectation) about many different things, and difficulty controlling that worry. This is often accompanied by restlessness, difficulties with concentration, irritability, muscular tension, and disturbed sleep.

Condition	Description
Health anxiety (hypochondriasis)	Characterised by a persistent preoccupation with the possibility that the patient has, or will have, a serious physical health problem. Normal or commonplace physical symptoms are often interpreted as abnormal and distressing, or as indicators of serious illness.
Irritable bowel syndrome (IBS)*	A common functional gastrointestinal disorder. It is a chronic, relapsing and often lifelong disorder, characterised by the presence of abdominal pain or discomfort associated with defaecation, a change in bowel habit together with disordered defaecation (constipation or diarrhoea or both), the sensation of abdominal distension and may include associated non-colonic symptoms. May cause associated dehydration, lack of sleep, anxiety and lethargy, which may lead to time off work, avoidance of stressful or social situations and significant reduction in quality of life.
Mixed anxiety and depressive disorder	A mild disorder characterised by symptoms of depression and anxiety that are **not intense enough** to meet criteria for a depressive disorder and/or an anxiety disorder but are nevertheless troublesome. This problem descriptor should not be used when an individual meets the criteria for a depressive disorder and one or more of the anxiety disorders; such people should be described as being comorbid for depression and the relevant anxiety disorder(s).
Medically Unexplained Symptoms (MUS)/ Persistent Physical Symptoms (PPSx) not otherwise specified*	Distressing physical symptoms that do not have an obvious underlying diagnosis and/or pathological process.
Obsessive-compulsive disorder (OCD)	Characterised by the recurrent presence of either an obsession (a patient's own unwanted thought, image or impulse that repeatedly enters the mind and is difficult to get rid of) or compulsions (repetitive behaviours or mental acts that the patient feels driven to perform, often in an attempt to expel or 'neutralise' an obsessive thought). Usually, a patient has both obsessions and compulsions.
Panic disorder	Repeated and unexpected attacks of intense anxiety accompanied by physical symptoms. There is a marked fear of future attacks, and this can result in avoidance of situations that may provoke a panic attack.
Post-traumatic stress disorder (PTSD)	The name given to one set of psychological and physical problems that can develop in response to particular threatening or distressing events, such as physical, sexual or emotional abuse, severe accidents, disasters and military action. Typical features of PTSD include repeated and intrusive distressing memories that can cause a feeling of 'reliving or re-experiencing' the trauma, emotional detachment and social withdrawal, avoidance of reminders and sleep disturbance.

Condition	Description
Social anxiety disorder (social phobia)	Characterised by intense fear of social or performance situations that results in considerable distress and in turn impacts on a patient's ability to function effectively in aspects of their daily life. Central to the disorder is a fear of doing or saying something that will lead to being judged negatively by others and being embarrassed or humiliated. Feared situations are avoided or endured with intense distress.
Specific phobias	Characterised by an extreme and persistent fear of a specific object or situation that is out of proportion to the actual danger or threat. This can include a fear of heights, flying, particular animals, seeing blood or receiving an injection.
*NHS Talking Therapies services are expected to treat these conditions as part of an integrated NHS Talking Therapies-LTC pathway and have staff who have received training in the treatment of these conditions.	

2.2 The impact of these conditions

Depression and anxiety disorders are extremely costly to individuals, the NHS and society.

The impact on the patient, families, and carers

Depression and anxiety disorders can lead to a range of adverse psychological, social and employment outcomes. These may include:

- **Greater distress and poorer quality of life**, including higher levels of self-reported misery and disruption to a patient's social, work and leisure life.
- **Poorer physical health**. For example, people with a diagnosis of depression (compared with those without) have a reduced life expectancy. They are also at increased risk of developing a physical health condition, such as heart disease, type 2 diabetes, stroke, lung disease, asthma or arthritis.
- **Unhealthy lifestyle choices**. Depression is associated with decreased physical activity and poorer adherence to dietary interventions and smoking cessation programmes.
- **Poorer educational attainment and employment outcomes.** There is a higher risk of educational underachievement and unemployment in people with depression and anxiety disorders. For those in employment, there is a higher risk of absenteeism, sub-standard performance and reduced earnings.
- **Increased risk of relapse** if treatment is not appropriate or timely.

The impact on the NHS

Healthcare costs for those with coexisting mental health problems and LTCs are significantly (around 50%) higher.[2] A large proportion of this cost is accounted for by increased use of physical health services (not mental health services).[3] For example:

- depression is associated with increased rehospitalisation rates in people with cardiovascular disease and chronic obstructive pulmonary disease (COPD), compared with the general population.[4 5]
- chronic repeat attenders account for 45% of primary care consultations and 8% of all emergency department attendances;[6 7] the most common cause of frequent attendance is an untreated mental health problem or MUS/ PPSx.[8 9]

- people with MUS/ PPSx who were not offered psychological therapies as part of their care were found to have a higher number of primary care consultations, than those who were;[10 11] similarly, people with COPD who were not offered psychological therapies as part of their care were found to have a higher number of urgent and emergency department admissions, than those who were.[12]

The impact on society

Together, depression and anxiety disorders are estimated to reduce England's national income (Gross National Product) by over 4% (approximately £80 billion).[11] This reduction in economic output results from increased unemployment, absenteeism and reduced productivity. This is accompanied by increased welfare expenditure.

3 The importance of delivering evidence-based care

The evidence base for the use of psychological therapies for the treatment of depression and anxiety disorders has been regularly and systematically reviewed by NICE since 2004. These reviews led to the publication of a series of clinical guidelines that recommend the use of certain psychological therapies.

3.1 Establishing the effectiveness of psychological therapies

To establish whether a particular treatment is effective, it is important to be able to understand first whether the intervention is beneficial (do people who receive the treatment improve more than people who have no treatment) and second, what aspect of the intervention leads to the improvement. The optimal method for establishing this comparison is a randomised controlled trial (RCT) where people are randomly allocated to different groups and the outcomes of the groups are compared. One group will receive the treatment in question while the other group(s) serve as control or comparison conditions. A group that is waiting for treatment will control for passage of time alone. Other groups might receive a placebo intervention, 'treatment as usual' or another new treatment.

RCTs are essential to finding out the real difference a treatment makes. One of the first RCTs of a psychological therapy for depression compared the delivery of cognitive behavioural therapy (CBT) with treatment with imipramine (an antidepressant) and showed that CBT achieved better results, both at the end of treatment and at follow-up a year later.[12]

RCTs are a substantial part of the evidence base from which NICE guidance is established.

3.2 NICE-recommended psychological therapies

Adherence to NICE-recommended evidence-based interventions optimises outcomes and forms one of the core principles of NHS Talking Therapies for anxiety and depression.

NICE-recommended therapies for depression and anxiety disorders are offered in line with a stepped/stratified-care model, when appropriately indicated (See Table 2). Low-intensity interventions (which vary by clinical condition but may include guided self-help (individual or group), digitally enabled therapy, psychoeducation groups and group-based physical activity programmes) have been identified as being effective for less severe cases of depression and less severe cases of some anxiety disorders.

For people with less severe depression who have not benefited from a low-intensity intervention, NICE recommends the following high-intensity psychological interventions:

- CBT (including behavioural activation),
- person-centred experiential counselling for depression (PCE-CfD),
- interpersonal psychotherapy (IPT),
- dynamic interpersonal therapy (DIT),
- behavioural couple therapy (BCT),
- couple therapy for depression (CTfD),
- mindfulness-based cognitive therapy (MBCT).

For more severe depression, high-intensity interventions recommended by NICE include:

- CBT (including behavioural activation),
- PCE-CfD,
- DIT, and
- IPT.

Various forms of specialised CBT are the NICE-recommended high-intensity treatments for specific anxiety disorders. In the case of PTSD and social anxiety disorder, it is recommended that high-intensity treatment is the first intervention because there is not a strong evidence base for low-intensity treatment. For PTSD, NICE recommends either Trauma Focused CBT or Eye Movement Desensitisation and Reprocessing (EMDR). See Table 2 for a list of NICE-recommended psychological interventions in NHS Talking Therapies services and the NHS Talking Therapies treatment packages resource for more information.

Table 2: NICE-recommended psychological interventions in NHS Talking Therapies (correct at March 2026)

	Condition	Psychological therapies	Source
Step 2: Low-intensity interventions (delivered by PWPs)[c]	Less severe depression	Individual Guided self-help based on CBT, group and/or individual Behavioural Activation, structured group physical activity programme, PWP supported digitally enabled therapy for depression which is supported for use in the NHS via a NICE early Value Assessment, complies with the DET Assessment Criteria, and has DTAC approval.	NICE guidelines: NG222, CG91, HTG675
	More severe depression	Individual problem solving, individual Guided self-help based on CBT, structured group physical activity programme	
	Generalised anxiety disorder	Self-help, or Guided self-help, based on CBT, psycho-educational groups, PWP supported digitally enabled therapy for generalised anxiety disorder which is supported for use in the NHS via a NICE early Value Assessment, complies with the DET Assessment Criteria, and has DTAC approval.	NICE guidelines: CG113, HTG676
	Panic disorder (with or without agoraphobia)	Self-help, or guided self-help, based on CBT, psycho-educational groups	NICE guideline: CG113,

[c] NICE does not recommend stepped care for the treatment of Social Anxiety Disorder. Instead all patients should be immediately offered the recommended high-intensity treatment in person or via a NICE EVA recommended digital treatment with high-intensity support. Low-intensity guided self-help can only be offered if the patient declines the relevant high-intensity treatment.

	Condition	Psychological therapies	Source
	Agoraphobia without panic	Guided self-help based on exposure therapy	Informal consensus of the EAG
	Low impact obsessive-compulsive disorder[d]	Guided self-help based on CBT (incorporating Exposure and Response Prevention)	NICE guidelines: CG31,
Step 3: High-intensity interventions (delivered by high-intensity therapists)	Depression For individuals with less severe depression for whom a low intensity intervention is not suitable or who have not responded to a low intensity intervention	CBT (individual or group) Group and/or individual Behavioural Activation (BA) Couple Therapy for Depression (CTfD) or Behavioural Couple Therapy; (BCT)[e] Interpersonal Psychotherapy (IPT) Person-Centred Experiential Counselling for Depression (PCE-CfD) Brief psychodynamic therapy (Dynamic Interpersonal Therapy; DIT) Group Mindfulness Based Cognitive Therapy (MBCT) **Note:** Psychological interventions can be provided in combination with antidepressant medication.	NICE guidelines: NG222, CG91,
	Depression More severe	CBT (individual), individual Behavioural Activation, PCE-CfD, DIT or IPT, each with or without medication **Note:** Psychological interventions can be provided in combination with antidepressant medication.	
	Chronic Depression	CBT with or without medication	

[d] The NHS Talking Therapies curriculum does not cover disorders related to OCD, such as trichotillomania and skin picking.

[e] If the relationship is considered to be contributing to the maintenance of the depression, and both parties wish to work together in therapy. NHS Talking Therapies recognises two forms of couple therapy and supports training courses in each. One closely follows the behavioural couple therapy model. The other is a broader approach with a systemic focus.

	Condition	Psychological therapies	Source
	Depression Prevention of relapse	CBT or mindfulness-based cognitive therapy[f]	
	Generalised anxiety disorder	CBT, Applied relaxation	NICE guidelines: CG113,
	Panic disorder (with or without agoraphobia)	CBT	NICE guidelines: CG113,
	Agoraphobia without panic	Exposure therapy	Informal consensus of the EAG
	PTSD	Trauma-focused CBT or Eye Movement Desensitisation and Reprocessing (EMDR) or HI supported digitally enabled therapy for PTSD which is supported for use in the NHS via a NICE early Value Assessment, complies with the DET Assessment Criteria, and has DTAC approval.[g]	NICE guidelines: NG116 HTG676
	Social anxiety disorder	High-intensity CBT specific for social anxiety disorder based on Clark & Wells or Heimberg protocols or HI supported digitally enabled therapy for Social anxiety disorder which is supported for use in the NHS via a NICE early Value Assessment, complies with the DET Assessment Criteria, and has DTAC approval.[h] [i].	NICE guideline: CG159 HTG676
	Health anxiety	Research literature supports effectiveness of high-intensity CBT.	No NICE guideline

[f] CBT during treatment in the acute episode and/or the addition of mindfulness-based cognitive therapy when the episode is largely resolved. Mindfulness is not recommended as a primary treatment for an acute depressive episode.

[g] NICE guidance does not include separate delivery of "stabilisation" interventions, and these are not recommended in NHS Talking Therapies.

[h] NICE guidance does not include separate delivery of "stabilisation" interventions, and these are not recommended in NHS Talking Therapies.

[i] NICE does not recommend stepped care for social anxiety disorder. Instead, all patients with social anxiety disorder should promptly be offered the recommended CBT protocol or digitally enabled therapy, each delivered by a high-intensity therapist. For social anxiety these treatments are more effective and cost-effective than guided self-help. Only patients who have been offered prompt access to the first choice high-intensity treatment and have refused for clinical reasons, can be offered guided self-help delivered by a PWP.

	Condition	Psychological therapies	Source
	Medium/ high impact OCD[j]	CBT (incorporating exposure and response prevention)	NICE guidelines: CG31,
	Body Dysmorphic Disorder (BDD)	CBT for BDD	NICE Guideline: CG31
	Chronic fatigue syndrome	Energy management, CBT for symptom management[k]	NICE guideline: NG206
	Chronic pain	Combined physical and psychological interventions, including CBT and exercise	NICE guideline: NG59 Informal consensus of the EAG[l]
	Irritable Bowel Syndrome	CBT	NICE guideline: CG61 Informal consensus of the EAG[l]
	MUS/ PPSx not otherwise specified	CBT	Informal consensus of the EAG[l]

[j] The NHS Talking Therapies curriculum does not cover disorders related to OCD, such as trichotillomania and skin picking.

[k] Specialised forms of CBT.

[l] The NHS England NHS Talking Therapies Expert Advisory Group (EAG) was convened to undertake a review of problem-specific systematic reviews and extrapolation from NICE guidance for the treatment of depression and anxiety disorders in the context of LTCs and for the treatment of MUS/ PPSx.

4 The workforce

4.1 Ensuring the competence and quality of the NHS Talking Therapies for anxiety and depression workforce

The right workforce, appropriately trained, with the right capacity and skills mix, is essential to ensuring the delivery of NICE-recommended care. The success of the NHS Talking Therapies programme depends on the quality of the workforce.

All NHS Talking Therapies clinicians should have completed an NHS Talking Therapies-accredited training programme, with nationally agreed curricula aligned to NICE guidance (or they should have acquired the relevant competences or skills before joining an NHS Talking Therapies service)[m]. All clinicians should be accredited and/or registered by relevant professional bodies and supervised weekly by appropriately trained supervisors.

The NHS Talking Therapies workforce consists of low-intensity practitioners and high-intensity therapists who together deliver the full range of NICE-recommended interventions for people with mild, moderate and severe depression and anxiety disorders, operating within a stepped/stratified care model. National guidance suggests that approximately 35% of the workforce should be psychological wellbeing practitioners (PWPs, also known as low-intensity therapists) and 65% high-intensity therapists (HITs).

All NHS Talking Therapies curricula and training materials can be found here.

4.1.1 Low-intensity workforce

PWPs deliver low-intensity interventions based on cognitive behavioural therapy (CBT) principles for people with depression and some anxiety disorders.

To work in an NHS Talking Therapies service, PWPs must complete a British Psychological Society (BPS) accredited PWP programme and register with either the BPS or the British Association for Behavioural and Cognitive Psychotherapies (BABCP). An apprenticeship version of the programme is also available. PWPs who work with long-term physical health conditions (LTCs) are also expected to have completed the relevant continuing professional development (CPD) course for working with LTCs. This is a compulsory top up module that all PWPs will normally be expected to complete within two years of qualification.

After PWPs have completed their BPS accredited PWP training programme there is an expectation for them to complete a one-year preceptorship. This is the responsibility of the employing service. It provides a co-ordinated approach to support, sustain, and develop PWPs during their first year after qualifying. See preceptorship guidance.

[m] A proportion of the workforce may have acquired relevant competences or skills before the development of NHS Talking Therapies training programmes. Such professionals are expected to be accredited by a relevant professional body that is recognised by NHS Talking Therapies.

Table 3: Low-intensity therapies training and course accreditation

Therapy type	Explanation of NICE-recommended therapy type	NHS Talking Therapies curricula	Course accredited by
Low-intensity therapy	Low-intensity evidence-based interventions including behavioural activation, graded exposure, exposure and response prevention, cognitive restructuring, managing panic, problem solving, sleep hygiene, worry management and supporting physical activity and medication adherence.	National Curriculum for Psychological Wellbeing Practitioner (PWP) Programmes	British Psychological Society
LTCs/ MUS/ PPSx	CPD programme for already-trained and accredited low-intensity therapists covering additional competences for working with LTCs/ MUS/ PPSx.	National LTC CPD Curriculum for Psychological Wellbeing Practitioners	N/A

4.1.2 High-intensity workforce

High-intensity therapists (HITs) deliver a range of NICE-recommended evidence-based psychological therapies, illustrated in Table 4. All therapists need to have been trained in the particular therapy or therapies that they deliver, with linked professional accreditation with the relevant professional body.

After therapists have completed their NHS Talking Therapies accredited training programme there is an expectation for them to complete a structured preceptorship year. This provides a coordinated approach to support, sustain and develop therapists during their first year after qualifying.

HITs who work with LTCs are also expected to have completed the relevant continuing professional development (CPD) course for working with LTCs. This is a compulsory top up module that all therapists will normally be expected to complete within two years of qualification.

Table 4: High-intensity therapies training and course accreditation[n]

High-intensity therapy type	Explanation of NICE-recommended therapy type	NHS Talking Therapies curricula	Course accredited by
Cognitive behavioural therapy (CBT)	A range of specialised CBT protocols for people with depression, anxiety disorders and PTSD.	National Curriculum for High Intensity Cognitive Behavioural Therapy Courses	British Association for Behavioural and Cognitive Psychotherapies
Person-Centred Experiential Counselling for Depression (PCE-CfD)	A particular type of counselling that has been developed for people with depression.	Curriculum for Counselling for Depression	British Association for Counselling and Psychotherapy
Couple therapy for depression	Can help people who have depression that may be linked to problems in their relationship with their partner. NHS Talking Therapies services offer two types, Behavioural Couple Therapy (BCT) or Couple Therapy for Depression (CTfD).	Curriculum for Couple Therapy for Depression Curriculum for Behavioural Couple Therapy for Depression	Tavistock Relationships British Association for Behavioural and Cognitive Psychotherapies
Brief dynamic interpersonal therapy (DIT)	A form of brief psychodynamic psychotherapy developed for treating depression. It can help people with emotional and relationship problems. It explores difficult things from the past that continue to affect the way people feel and behave in the present. It is also referred to as short-term psychodynamic psychotherapy.	Curriculum for High-Intensity Brief Dynamic Interpersonal Therapy	British Psychoanalytic Council
Interpersonal psychotherapy for depression (IPT)	Time-limited and structured. Its central idea is that psychological symptoms, such as depressed mood, can be understood as a response to current difficulties in relationships and affect the quality of those relationships.	Curriculum for Practitioner Training in Interpersonal Psychotherapy	Interpersonal Psychotherapy Network UK
Eye Movement Desensitisation	A psychotherapy model that has been developed to help	Curriculum for Eye Movement	EMDR Association UK

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

High-intensity therapy type	Explanation of NICE-recommended therapy type	NHS Talking Therapies curricula	Course accredited by
and Reprocessing (EMDR)	people who have post-traumatic stress disorder (PTSD). People who have PTSD may experience intrusive thoughts, memories, nightmares, or flashbacks of traumatic events in their past. EMDR helps to reprocess memories of the traumatic event so the negative images, emotions, and physical feelings they cause reduce, leading to a change of perspective and focus on the present and future.	Desensitisation and Reprocessing For those who have not undertaken the national EMDR curriculum training the national clinical governance guidance criteria for EMDR practice should be met.	
Mindfulness-based cognitive therapy (MBCT)	Combines mindfulness meditation techniques with cognitive therapy, which is about learning how to manage your thoughts and how they make you feel. It is a treatment for less severe depression and is also particularly helpful for preventing relapse in people with a history of recurrent depression.	Curriculum for Mindfulness-based Cognitive Therapy	British Association of Mindfulness Based Approaches (BAMBA)
LTCs/ MUS/ PPSx	CPD programme for already-trained and accredited high-intensity therapists covering additional competences for working with LTCs/ MUS/ PPSx.	National LTC CPD Curriculum for High-Intensity Therapists National LTC CPD Curriculum for HIT modalities other than CBT	N/A

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

Table 5 is the recommended percentage each system/ provider should have within their HIT skill mix, providing the % range that systems should be working to achieve, based on their population need.

Table 5: Recommended national and service level skill mix

Training	Required % HIT capacity per service
Cognitive Behavioural Therapy (CBT)	75-90
Person-Centred Experiential Counselling for Depression (PCE-CfD)	0-6
Interpersonal Psychotherapy (IPT)	0-6
Dynamic Interpersonal Therapy (DIT)	0-6
Behavioural Couple Therapy (BCT)	0-8
Couple Therapy for Depression (CTfD)	0-8
Eye Movement Desensitisation and Reprocessing (EMDR)	0-7
Mindfulness-based cognitive therapy (MBCT)	0-2

4.1.3 Training and accreditation requirements

PWP training requirement for entry

All PWPs should have passed a BPS-accredited PWP programme. If qualifying by the apprenticeship route they should in addition have passed the apprenticeship end-point assessment[o].

The only exceptions to this will be those who have completed one of the following:

- The NHSE commissioned 2021 'PWP Assessment of Competence Scheme'. This offered a one-off opportunity to assess competence of those who were already working in NHS Talking Therapies services as PWPs prior to January 2020 but who had not completed a BPS-accredited programme.
- A core professional training or non-accredited PWP training plus the BPS accredited PWP top-up training (up to 2016).
- The forerunner trainings in 2005–08 at the University of York on which the national PWP curriculum was later based. Individuals may therefore be considered to have a recognised PWP training when they are graduates of the following programme with evidence of either MSc or PGCert award during the period 2005–08:

    - University of York MSc in Mental Health Care (Primary Care Mental Health) (incorporating the Postgraduate Certificate in Mental Health Care [Primary Care Mental Health] for Graduate Primary Care Mental Health Workers).

    - Individuals who can evidence that they are holders of a valid certificate

[o] Where Apprenticeship Standard 2.0 has been applied, there is no longer a non-integrated End Point Assessment for the PWP Apprenticeship. Apprenticeships who have completed Standard 2.0 will only require the BPS accredited qualification.

of competence from an in-service training provided by the University of York to the Doncaster Case Managers who worked in the Doncaster NHS Talking Therapies Pilot site in the period 2005–08.

Trainee PWPs should all be currently registered as students on a BPS-accredited PWP programme or PWP apprenticeship. PWP interventions should only be delivered by PWPs, trainee PWPs or high-intensity therapists who meet the criteria to deliver a high-intensity NHS Talking Therapies intervention and have in addition demonstrated competence to deliver PWP interventions. Training of PWPs outside of a BPS-accredited PWP programme is not recognised. Specifically, training as a Mental Health and Wellbeing Practitioner or in the Children and Young People's mental health programme as a Children's Wellbeing Practitioner or Education Mental Health Practitioner does not lead to competence as a PWP for NHS Talking Therapies and is not transferable. PWP training also does not equip a practitioner with competences to work in Children and Young People's mental health or Mental Health Support Teams for children and young people.

HIT training requirement for entry

High-intensity therapists working in NHS Talking Therapies services should either:

- Have completed the Manual-recognised NHS Talking Therapies qualification to deliver the therapy or therapies that they deliver in NHS Talking Therapies, and gain and maintain the recognised individual accreditation to deliver these within 1 year of qualifying, **or**
- Have the Manual-recognised individual accreditation to deliver the therapy or therapies that they deliver in NHS Talking Therapies.

Accreditation and maintaining competence

PWPs are required to maintain continuous individual registration as a PWP with either the BABCP or the BPS - see Appendix A.

HITs are required to maintain continuous individual registration/ accreditation of the type set out in Appendix A that is relevant to the therapy or therapies that they provide in NHS Talking Therapies services.

Registration/ accreditation serves three purposes:

1. It assures the public that core standards of professional and ethical behaviour have been adhered to by a practitioner,
2. It identifies practitioners with relevant competences to deliver particular psychological interventions,
3. It ensures that practitioners work within the required "system of care" for effective practice.

For some NHS Talking Therapies interventions, an individual registration/ accreditation is necessary but not sufficient for purpose. In these cases, a specific NHS Talking Therapies therapeutic modality training must be completed in addition to the registration/ accreditation. The practitioner is then expected to maintain competence in the specific NHS Talking Therapies intervention as part of meeting their ongoing accreditation requirements.

To support ongoing registration/ accreditation, practitioners should maintain and develop skills through regular CPD.

Transitional arrangements for staff without the required qualifications and accreditations

Where staff do not have the required qualifications and registrations/ accreditations, the clinical lead for the service will need to put in place transitional arrangements to ensure that the service is safe for patients and that the qualifications and registrations/ accreditations of staff are transparent for the public using the service. A robust and urgent plan should be made to register staff onto the required training or for them to seek the required registrations/ accreditations without delay. For patient safety, it may be necessary to stop staff from practicing alone until they are registered as trainees or have the required registration/ accreditation in place.

4.1.4 Clinical leadership

Effective leadership is essential to create a culture of shared and distributed leadership for all staff to take accountability for performance and drive forward continuous quality improvement. Balancing effective and efficient service delivery with compassion and keeping person-centred coordinated care at the centre by involving patients in the development and improvement of services, are important actions to guard against the potential negative effects of target-driven cultures. Leaders must ensure that delivering evidence-based NICE-recommended therapies remains at the heart of service provision through effective clinical governance.

Transformational leadership can be challenging in the context of difficult financial situations, staff turnover and performance demands from local commissioners and NHS England. However, leadership should facilitate improved patient outcomes and result in staff feeling supported and appreciated, at the same time as creating an innovative environment in which the information captured by NHS Talking Therapies data reports is seen as a source of good ideas that everyone can participate in, rather than a mechanism for harsh performance management.

4.1.5 Non-clinical and additional workforce

Clinical and operational leaders should balance a supportive, nurturing and innovative environment in which staff can thrive with a focus on achieving key performance metrics through performance management.

It is important to connect regularly with clinical networks that have a remit for quality improvement, use data to drive improvements, share good practice and support regional training solutions. Attending organised events can support and enhance local delivery.

Building relationships with key stakeholders, including GPs that can champion the service, and connecting with the wider system will support local pathway development and ensure people get to the right service at the right time.

Employment advisers within NHS Talking Therapies offer a range of support and advice on issues related to employment to patients who are in and out of work. See Section 11.5 for further detail.

Senior employment advisers to manage the EAs, ensure the EAs are working alongside therapists and work with wider community support.

Deputy senior employment advisers assist senior employment advisers to supervise the employment advisers

Data analysts have a crucial role within NHS Talking Therapies services because data quality is a key feature of the programme's success. Ensuring alignment of national and local reporting is an essential task since commissioners are performance managed on national, not local, reports. Providing more in-depth local reports for analysis can support staff and managers to understand and improve the quality of the service provided.

Administrative staff are essential to the effective functioning of services. A robust administrative system can support productivity and, with the implementation of lean systems, can support timely access into the service, as well as efficient mechanisms to support the flow through the system.

Assistant roles, such as assistant psychologists and assistant PWPs are not clinical delivery roles in NHS Talking Therapies but can be helpful in driving forward service quality improvement initiatives. In some situations, assistants may join a qualified clinician in a session, to assist (particularly with groups). However, they should not run sessions on their own and must not deliver triage, clinical assessments, or interventions independently without a qualified NHS Talking Therapies clinician present and leading.

Clinical psychology doctorate trainees can undertake both direct therapeutic work, and wider work across the care pathway to support service delivery. Many NHS Talking Therapies services have good relationships with their local clinical psychology programmes and value taking trainees on placement as additional clinical support. Trainee clinical psychologists are fully funded by the NHS outside of NHS Talking Therapies, so there are no salary costs to the service. The only costs to the NHS Talking Therapies service are the supervision and any infrastructure costs. On completion of a BABCP Level 2 accredited training pathway within their Doctorate, clinical psychologists will be eligible to work in NHS Talking Therapies as HITs providing CBT.

4.1.6 Competences and training

To be effective, NICE-recommended psychological therapies need to be delivered by individuals who have developed all the relevant competences that underline the treatments. Roth and Pilling have developed competence frameworks for each of the therapies supported by the NHS Talking Therapies programme. Courses that are delivering the agreed NHS Talking Therapies training curricula assess trainees against this competence framework. Clinicians may also wish to consult the frameworks when considering the need for any CPD. Commissioners should be familiar with the frameworks to ensure that services are employing clinicians with the relevant clinical skills.

All clinicians within an NHS Talking Therapies service should receive mandatory and statutory training in line with organisational policy.

All EAs should complete the EA Induction programme to ensure their competence to deliver employment support safely within an NHS Talking Therapies setting.

The importance of in-service training

A key feature for the NHS Talking Therapies programme is the in-service training opportunity. Trainees have the advantage of being able to practice, daily, the required skills for the therapies they are being trained to deliver, with the people who are experiencing the relevant clinical problems. Initial training cases should not be overly complex. Caseloads should be reduced to encourage reflective practice. Modelling is one of the optimal ways of learning clinical skills, so it is strongly recommended that trainees have an opportunity to sit in on therapy sessions with more experienced clinical staff.

Continuing professional development

CPD is critical to improving outcomes for people receiving treatment and for supporting staff wellbeing. Regular CPD opportunities (within the service through observation and peer learning opportunities as well as by attending external events) should be provided for all NHS Talking Therapies staff aligned to individual needs, professional body requirements and to the therapies that they are delivering, this should also form part of the supervision process (see Section 4.1.7). Access to high-quality therapist dashboards can facilitate a targeted approach to CPD by highlighting areas of developmental need.

A key quality standard for NHS Talking Therapies services is to maintain a stable core of trained, accredited/ registered clinicians who represent a mix of seniority across the different therapeutic modalities and can support others in their development. Developing staff (including PWPs) for more complex roles or maintaining performance levels in existing roles is important to enable a balanced skill mix to support more complex clinical work. Services need to build capability and capacity to safely manage severe and complex cases. This does not include working outside of NICE guidelines.

4.1.7 Supervision

Effective supervision is fundamental to the success of the NHS Talking Therapies programme. This is both from a patient and therapist perspective. The three essential functions of supervision are to improve outcomes for people receiving treatment, provide support to individual therapists, and improve therapist performance and professional development. Services that do not have effective models of supervision in place will see this reflected in poor clinical outcomes, treatment waits, reduced therapist wellbeing and increased therapist turnover.

Purpose of supervision

Figure 3: Purpose of supervision

Fidelity to evidence base	Ensuring therapists and practitioners choose treatments and use them in a way which is as close as possible to the protocols tested in clinical trials which have led to these treatments being recommended in clinical guidelines.
Case management	Ensuring all patients are reviewed according to specific clinical and organisational criteria in order to make effective and efficient clinical decisions, often relating to treatment response, treatment length, treatment intensity or treatment alternatives.
Clinical governance	Ensuring safety for patients and therapists, by routinely reviewing patient risk and therapists' clinical practice for ALL patients, not just those that a supervisee or supervisor selects for discussion.
Skills development	Assisting therapists to improve their own clinical and therapeutic skills by supervisor feedback on therapists' sessions, e.g., through direct observation, review of notes or taped recordings.
Therapist support	Ensuring that therapists' own mental health is addressed where they are working with emotionally difficult material, high clinical volumes or are themselves in distress unrelated to their work.

Types of supervision

- Clinical case management supervision
- Clinical skills supervision
- Meta supervision (supervision of supervision)
- Peer supervision
- Reflective practice/ supervision
- Line management supervision

Competencies required by NHS Talking Therapies supervisors

A supervision competence framework for psychological therapies has been published by UCL, providing further support and guidance on the competences required to deliver different forms of supervision in NHS Talking Therapies for anxiety and depression. Alongside this, frameworks for specific therapy modalities and for their supervision are also available.

All good-quality supervision rests on supervisors having the set of competences described in these frameworks.

NHS Talking Therapies supervision: key principles (PWPs and HI Therapists)

The following principles apply to all clinical staff working within NHS Talking Therapies. This includes those working on temporary contracts, e.g., bank/ agency. For further details of how the principles apply to PWPs see the PWP Supervision Guidance and Best Practice resource.

Supervision format:

- Weekly supervision, consisting of at least one hour per week of individual supervision with an experienced and trained NHS Talking Therapies supervisor, with a focus on individual patient outcomes, during which detailed clinical decision-making issues can be reflected upon, discussed and resolved, and in which there is also a focus on practitioner wellbeing and equality, diversity and inclusion issues. *All cases on the therapist's caseload should be discussed regularly during the course of treatment.* In this way, supervision can help guide the course of treatment
- To manage the varying supervision needs of their therapists, some services offer a mix of individual and small group supervision. Small modality specific group supervision can offer therapists the opportunity to learn from other similarly qualified therapists and expand their skills through sharing of good practice.
- Small group supervision duration should be designed around the function and size of the group. There should be time for every participant to contribute actively and discuss their own cases regularly in supervision. Group supervision that allows review of some cases for each participant would require at least 20-30 minutes per participant in the group.
- For part-time staff, reduced caseload may mean that the duration of supervision could be proportionately reduced. However, supervision frequency should not be reduced as this allows for timely review of cases.
- Clinical case management supervision should be separate from operational line management supervision and undertaken by different personnel.
- PWPs should receive both case management supervision (individual, 1 hour per week, allowing outcome-focused clinical decision-making based on case discussion and observation of practice, and with a focus on practitioner wellbeing) and clinical skills supervision, with a focus on maintaining and extending clinical skills (at least 1 hour per fortnight, in a group of no more than 12 participants).
- HI Therapists: The primary focus of supervision is to identify ways of maximising clinical outcomes of all patients currently in treatment. This means integrating detailed case discussion with a broader review of all cases. There should be a shared running record of key features of all cases on the therapist's caseload (e.g. problem descriptor, outcome measures at baseline and at last attended session, number of sessions to date, and date of last attendance). It is not possible to discuss all cases in detail in a single supervision session, especially as supervision should provide sufficient time to identify meaningful plans for individual patients. However, all patients should be discussed over a period of several weeks, so that there is an opportunity to use supervision to adjust delivery of each patient's treatment while the therapy is ongoing. Supervisor and supervisee should escalate cases for discussion from the document as required. This should include managing overall caseload in line with available clinical capacity.
- For HI therapists who deliver more than one therapy modality, the supervision package should meet all of the following requirements:
    - At least one hour per week of individual supervision with an experienced and trained NHS Talking Therapies Supervisor described in the first bullet point above.
    - Sufficient modality specific supervision in each modality

to meet registration/accreditation requirements for the modality and to maintain competence, fidelity and effectiveness. This can be delivered in group or individual format, as set out under the third bullet point above.

- Supervision effectiveness is increased through regular direct observation of audio/video recorded practice.

The amount and mode of supervision for each modality will be influenced by the amount of time spent delivering each type of therapy and the specific modality requirements for competence and registration/accreditation.

- Additional supervision for trainees:
  - High-intensity trainees should receive additional supervision of training cases, lasting 1.5 hours within their 2-day attendance on the course at a university.
  - Doing co-therapy/intervention with a HIT or PWP trainee, and discussing the session afterwards, can be an excellent way of helping them acquire important clinical skills.
  - Supervision of trainees includes evaluating and feeding back on competence development and at times, sharing this information with education providers. This component should be explicit within supervision contracts.

Supervision content:

- Outcomes-focused supervision that starts by looking at the patients' questionnaire scores and any change to these.
- Over a period of several weeks all ongoing clinical cases should be reviewed in supervision. It is important not to focus only on difficult cases or those that are doing well – at least briefly discussing the full range of cases over several weeks enhances learning and builds confidence.
- Some live or recorded observation within supervision should take place to allow detailed feedback on practice issues and fidelity to the model, including the use of modality specific fidelity/ competence rating scales. This is the case for both trainees and qualified staff.
- Discussion of clinical cases should be prioritised according to need.
- When supervising LTC cases, it is important to have knowledge of the presenting physical health condition/s and receive appropriate supervision with health professionals with disease-specific expertise as required.
- Cultural competence should be considered, as well as how supervision can support the supervisee to meet individual need.

Modality:

- Supervision that is model-appropriate to support the modality being delivered.
- Supervisors need to be competent in, and have personal clinical expertise in, the therapeutic models and approaches they are supervising.
- Where therapists are qualified in more than one modality, services will need to ensure that adequate modality specific supervision is provided.
- The amount of supervision in each modality needs to be in line with the amount of clinical work offered in that modality e.g., if a therapist provides CBT to 50% and IPT to 50% of their caseload, their clinical supervision should reflect this split.

Supervisor Training and Competence:

- All supervisors (across all modalities) should have completed one of the NHS Talking Therapies supervisor-specific training programmes and be able to demonstrate generic, specific, and model-specific supervision competences.
- It is recommended that supervisors have a minimum of two years of qualified experience of fully NHS Talking Therapies recognised qualified practice of the interventions they are supervising. No supervisor in NHS Talking Therapies should have less than 12 months of this qualified experience.
- PWP supervisors need to be able to demonstrate the generic, specific and Low Intensity competences from the UCL CBT competence framework, as well as the generic, specific and Low Intensity CBT supervision competences from the UCL Psychological Therapies Supervision framework and have attended the NHS Talking Therapies supervisor training.
- HIT supervisors need to be able to demonstrate the generic, specific and High Intensity competences for their modality from the relevant UCL competence framework, as well as the generic, specific and high-intensity supervision competences from the UCL Psychological Therapies Supervision framework and have attended the NHS Talking Therapies supervisor training.
- A named senior therapist should be responsible for overseeing the delivery, implementation, monitoring, and effectiveness of supervision within the service, in conjunction with the clinical lead/ director and course directors (for trainees) concerned.
- Supervisors should have an opportunity to consult colleagues regularly for meta-supervision (supervision of supervision).
- Supervisors should have opportunities to undertake CPD specifically focused on maintaining and extending supervision competence.

Employment Adviser competence:

- All EAs should complete the EA Induction programme to ensure their competence to deliver employment support safely within an NHS Talking Therapies setting.

4.1.8 Pay

NHS Talking Therapies services should not contract with any individuals with NHS Talking Therapies-recognised qualifications and accreditations/ registrations, or those undertaking NHS Talking Therapies modality trainings, to operate in any unpaid capacity. Services should offer substantive trainee employment contracts to PWP and HIT trainees that automatically become permanent contracts and move up to the appropriate grade on successful completion of the course and application for registration and avoid contracts with practitioners that only remunerate them for sessions attended. The only exceptions are integrated Masters degrees that include BPS accredited PWP training, where placement may be unpaid.

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

Recommended banding

Trainee PWPs should be employed and paid at AfC Band 4. Once qualified and registered with the appropriate professional body, this banding should be adjusted to AfC Band 5. Due to variation in processing times for registration, Band 5 uplifts should normally be backdated to the date of registration application subject to Agenda for Change rules and local HR protocols.

Trainee HITs should be employed and paid at AfC Band 6. Once qualified and accredited with the appropriate professional body, this banding should be adjusted to AfC Band 7. This applies to all Step 3 modality therapists. Due to variation in processing times for accreditation, Band 7 uplifts should normally be backdated to the date of accreditation application subject to Agenda for Change rules and local HR protocols.

Services should follow Agenda for Change rules and local HR protocols for starting salary which may require and recognise the need for appointment of trainees above the bottom of the pay band.

Senior and lead clinical roles should be developed in every service for both PWPs (Band 6+) and HIT therapists across modalities (Band 8a+). This supports career development and retention within the service. Senior roles should include expert delivery of psychological therapy to patients as well as supervision and leadership.

For employment support staff employed by the NHS, it is recommended that employment advisers employment advisers are paid at AfC Band 4 (we are aware that some NHS Talking Therapies services pay EAs AfC Band 5). Deputy Senior Employment Advisers are paid at AfC Band 5, and Senior Employment Advisers are to be paid at AfC Band 6. Employment support staff who are contracted in, and non-NHS staff, should be paid in line with their employers pay scales using the NHS AfC recommendations as a guide.

4.2 Staff wellbeing

Staff wellbeing is paramount. Creating a resilient, thriving workforce is essential to delivering high-quality mental healthcare as staff wellbeing correlates to better outcomes for patients. A highly challenging professional context should be matched with high levels of support. Productivity aspirations should be based on workloads that are consistent with professional and ethical guidelines for sustainable quality of care.

As good practice, providers should implement local strategies to improve and sustain staff wellbeing. It is recommended that services have a written plan for supporting staff wellbeing, which is developed with staff and updated on a regular basis. For an example, see the Model NHS Talking Therapies Staff Wellbeing Strategy developed by the Thames Valley NHS Talking Therapies services.

Elements could include:

Good leadership and management:

- Effective clinical leadership, clear line management with excellent team communication, attention to staff support, openness to feedback and alertness to signs of stress in the workforce.

- Training and support for line managers to allow them to manage staff effectively and compassionately, particularly in relation to performance management and that clinicians have a manageable working week.
- Staff engagement and input in decision-making, service improvement and managing change.
- Ensure that all newly qualified clinicians follow a preceptorship programme for 12 months post qualification. A staff survey post-preceptorship is recommended to identify outstanding areas of development and potential issues.
  The preceptorship programme could include:
    - Preceptors – each preceptee is assigned a preceptor who they meet regularly.
    - Workshops – workshops on various topics not covered in formal training.
    - Reflective practice sessions – a less structured space to explore anything that affects the preceptee's work.
    - Portfolio – collection of reflections on workshop content and reflective practice sessions.
    - Regional forums for newly qualified clinicians to share experiences, learning etc.
- Offer coaching and mentoring to all: the NHS Leadership Academy has resources that can be used.
- A pastoral approach to line management supervision is recommended. Feedback suggested that 'Wellness Action Plans' (Mind) for all staff are extremely powerful and supportive.

The right working environment:

- Ensuring a healthy and safe working environment where staff are equipped with the resources and equipment needed for their roles, including an appropriate IT system and admin staff support.
- Ensuring staff have sufficient time to manage their caseloads and deal with unpredictable risk issues within their contracted working hours.
- Staff should have time for appropriate lunch and other breaks and should not regularly work overtime.
- Minimise the 'noise' in the role to ensure that clinicians are spending as much of their time as is possible on using the unique skills they have e.g., clinical work. This could mean increasing administration support or considering digital innovations to book appointments, manage waits lists etc.

Effective supervision:

- Ensuring weekly outcomes-focused supervision with appropriately trained supervisors and benefit.

Appropriate levels of clinical complexity:

- Service operates within the NHS Talking Therapies framework, allowing staff to work with NHS Talking Therapies-appropriate cases for which they have received suitable training.
- Access to, and presence of, more experienced staff to support working with more severe or complex cases and managing risk issues when they arise.

Training and Continuing Professional Development (CPD):

- Provision of high-quality ongoing training and CPD that is recognised, relevant to the role and targeted to the individual needs of clinicians, as identified in supervision.
    - Training could include specific focus on positive practice guides (PPGs); grief/ adjustment; emotional regulation; motivational interviewing; managing complexity; skills developments (e.g., difficult conversations, communicating situations in which NHS Talking Therapies cannot meet a patient's needs); back to basics (to discourage role drift).
- Comprehensive CPD programmes planned in advance that include the cascading of training by staff who have attended courses.
- Opportunity to join special interest groups and regional networks such as the Psychological Professions Network (PPN).
- Profession-specific forums to develop further skills and expertise.
- Career development opportunities.
- Introduction of staff champions, for example specific protected characteristics, digital, staff wellbeing, and so on.
- Supporting trainees to fulfil the training requirements of their course, recognising that they cannot deliver the workload of qualified staff.

Wellbeing initiatives:

- Ensuring that all staff have opportunities for training and development in dealing with the emotional aspects of their role.
- Developing resources for looking after yourself and managing wellbeing for all staff and ensuring that staff have a chance to follow up on these.
- Develop staff wellbeing forums.

A supportive culture:

- A staff wellbeing agreement could be included in the local induction process, to help shape a culture that puts patients and staff at the heart.
- Staff turnover should be monitored via 'exit interviews', and any learning implemented to improve retention.
- Incorporating wellbeing activities to support team building (such as away days and events); this facilitates resilient teams and team effectiveness, which is linked to improvements in the quality of care that patients receive.
- Identify whether any staff spend an excessive amount of their time in lone/ isolated/ home working environments and take steps to reconnect them with the team.
- Providing timely and appropriate occupational health services, when required.
- Staff wellbeing should be an ongoing agenda item in team meetings and discussed in both supervision and appraisals.
- Direction, alignment, and commitment – an inspiring lived vision, a limited number of clear, agreed challenging goals, alignment of efforts around core purpose and climates of trust, psychological safety, and motivation.
- Consider the messaging (regionally and locally) that is shared and used with regards to the skills held by our clinicians and the intrinsic value they have within the NHS Talking Therapies model.

4.3 Workforce retention

In NHS Talking Therapies services, staff retention of high-intensity therapists (HITs) is generally good. However, there has been some difficulty in retaining the low-intensity workforce (PWPs). In particular, many PWPs move into HIT training after a very short period in role. While it is encouraging that these individuals remain committed to the NHS Talking Therapies programme, it is difficult to organise CPD initiatives and maintain key performance metrics if individuals only briefly stay as PWPs. It is strongly recommended that PWPs stay in role for at least three years after completing their training, to ensure that they consolidate their learning and further develop their skills. PWPs will not be funded for HIT training or other NHS funded psychological professions training until two years after completing their PWP qualification / apprenticeship. More details are contained in the policy for NHS funding for psychological professions training programmes [p].

Standards of good practice for the retention of the workforce

- Services should aim to recruit staff from a range of backgrounds, to create a diverse workforce with a substantial number of people who will be keen to continue developing within their role.
- Supporting part-time training and working is likely to help create a more diverse and stable workforce.

Career progression and variety in role

- Every service should develop career development opportunities, including Senior PWP and Lead PWP positions, as well as offering attendance at accredited supervision training, which can support retention. Senior and Lead roles should include clinical leadership and clinical practice, and not be restricted to management functions.
- Developing specialities and variety within PWP and HIT roles can support retention. This can be achieved by creating 'champions' across areas of service improvement and development. For example, champions for older people, people from ethnic minority groups, younger adults,[q] perinatal mental health, armed forces veterans, and people with LTCs or MUS/ PPSx – roles could be linked to PPGs. Throughout medicine, people who specialise their treatment work in a particular area tend to get better results (see surgery outcome data) and, in many cases may have better job satisfaction.
- Career development opportunities should consider banding progression. An NHS Talking Therapies workforce across a range of pay bands with recognised developmental and promotion pathways demonstrates opportunities for stepwise progression within and beyond current roles.
- Development opportunities could also be provided within operational management. Not all NHS Talking Therapies clinicians wish to progress their career clinically, some would prefer to develop their skill set operationally. Opportunities within these areas support the individual to remain in the NHS Talking Therapies workforce and use their clinical skills to develop other clinicians. Such opportunities could also include leadership training.
- Consider linking clinicians to specific GP Practices to give a sense of ownership and an ability to educate primary care colleagues on NHS Talking Therapies, the

[p] This rule should be applied in such a way that it confers no disadvantage as a result of any protected characteristic. As such, periods of maternity leave should be counted towards the two years, and evidenced gaps in employment because of disability, illness or caring responsibilities should also be considered part of the 2 years. See the policy for NHS funding of psychological professions training programmes.
[q] People aged between 18 and 25 years.

stepped/stratified care model and the vital role NHS Talking Therapies plays within mental healthcare.

- For many clinicians it is important to have variety in the role. For those that want this variety, consider expanding job activity to include individual assessment and treatment, evidence-based groups, supervision of others, projects, research, teaching etc. It is also important that clinicians have the ability to deliver assessment and treatment in a number of ways e.g., by telephone, video platform, in person, and through digitally enabled treatments. It is important to bear in mind the earlier point about some people preferring to focus their main treatment work on a smaller range of clinical problems and become an expert in treating those problems. As such, it is important to consider each clinician individually, as well as forming part of a wider team.

For further information about workforce recruitment and retention, see the FutureNHS workspace.

4.4 Workforce data collection

To support workforce planning and the commissioning of training, accurate data on the NHS Talking Therapies workforce is required from all NHS Talking Therapies services. This is usually collected at an institutional level, via the Trust or independent/ third sector human resources departments using the Workforce Minimum Data Set collected by NHS England.

All NHS Talking Therapies services are required to record their workforce accurately according to the occupational codes required by the NHS workforce data standard. This will require updating of historic workforce coding to reflect the most current coding scheme. All NHS Talking Therapies Providers (NHS, independent, and third sector) are required to supply the Workforce Minimum Data Set to NHS England to allow accurate tracking of workforce. The revised NHS Talking Therapies Data set (still known as the IAPT Data set) requires services to record, for every member of the clinical workforce their qualifications, (gained or currently training), for delivering particular NHS Talking Therapies-compliant treatments.

The NHS Benchmarking Network conducts a census of the NHS Talking Therapies workforce annually. The purpose of this census is to establish a current national workforce position within NHS Talking Therapies. This allows for comparison with previous annual submissions to provide an accurate picture of total workforce expansion and where this is in relation to the NHS Long-Term Plan and subsequent policy trajectories. The workforce census covers NHS commissioned NHS Talking Therapies services delivered by NHS and non-NHS service providers. The results of the NHS Talking Therapies workforce census are published annually by NHS England.

5 Delivering effective assessment and treatment

5.1 A good assessment

A person-centred assessment completed by a trained clinician is a crucial part of the NHS Talking Therapies for anxiety and depression care pathway. A good assessment should accurately identify the presenting problem(s), make an informed clinical decision about the patient's suitability for the service, determine the appropriate NICE-recommended treatment and step in collaboration with the patient, develop a safety formulation, identify the correct outcome measures to assess change, generate hope, and explain to patients what treatment involves. It should also explore patient circumstances and needs to ensure manageable scheduling of therapy.

Some services use online forms or "digital front-doors" to collect information in advance of a patient's initial meeting with the NHS Talking Therapies clinician. Prior review of this information gives the clinician and patient more time for an in-depth conversation and as a consequence, may improve the quality and accuracy of the assessment. The clinician's judgement remains paramount. Online forms or digital front-doors should never be used to automatically assign a problem descriptor or make a decision about the treatment the patient will receive in Talking Therapies services or elsewhere. Patients should be informed that digital front-doors and online forms are optional, do not bypass the need for assessment and do not provide faster access to treatment. NICE has published an Early Value Assessment which recommends which digital front-doors are appropriate for use in the NHS while further evidence is generated and further guidance on implementing digital tools across the NHS Talking Therapies pathway is also available

5.1.1 Components of a good assessment

The initial assessment must always be conducted in a 1:1 capacity, in real-time either face-to-face or over video- or telephone-call and should cover the following areas:

- **Providing information about the service.** People should be given clear information about the service, the clinician's role and the purpose of the assessment, including information about confidentiality, the limits to confidentiality and informed consent.
- **Presenting problem(s):**
    - the patient's view of the current main problem(s) and the impact on their life
    - history of mental health problems
    - an exploration of any psychological processes that are likely to maintain the patient's presenting problems, such as:
        - safety behaviours and avoidance
        - attention
        - memory
        - problematic beliefs
    - an exploration of any adverse circumstances that maintain a patient's presenting symptoms, this could include factors such as:
        - physical health (including any long-term conditions)
        - debt
        - domestic violence
        - Racial trauma or other forms of discrimination

        - isolation
        - homelessness or inadequate housing
        - asylum status
        - relationship difficulties
        - employment status
        - information about the patient's use of prescribed and non-prescribed medication (for example, drug and alcohol misuse)
    - identification of the appropriate problem descriptor(s) (International Statistical Classification of Diseases and Related Health Problems 10th edition [ICD-10] code)
    - the duration of the current episode of the agreed mental health problem(s) that will be the focus of treatment. the patient's goals for treatment

- **Assessment of risk and safeguarding** (including self-harm or suicide, or harm to others). All forms of risk (to self, to others, and from others) should be carefully explored and responded to. As detailed in Staying safe from suicide: Best practice guidance for safety assessment, formulation and management, for suicide safety practitioners should recognise that anyone can experience suicidal impulses and that these are highly volatile depending on presence of unique triggers or absence of unique protective factors. HIT and LI practitioners should undertake comprehensive psychosocial assessment and formulation of risk, leading to a safety plan for all patients where there are any immediate or future safety concerns. Standardised risk assessment questions can be included, and risks taken account of within this assessment (e.g. the risk question on PHQ-9). However, standardised risk assessment questions are very poor predictors of risk when used in isolation. Of those in contact with mental health services who complete suicide, four out of five were rated at the most recent contact as "low risk". Clinicians should therefore move away from attempts at risk prediction to safety-planning for all. Decisions about intervention or service provision should not be based on standardised risk questions alone. Clinicians should not use risk stratification (e.g., as "low, medium or high" risk). All clinical staff should undertake training in the recommended approach, such as that published by MindEd.
- **Purpose and importance of outcome measures.** Explain the rationale for outcomes measures. What they cover (symptoms and the way those symptoms interfere with your life); How they are administered (to be filled in before each session, usually online); and why they are helpful (help your therapist/practitioner track progress and make any adjustments to treatment that may be required).
- **Completion of the NHS Talking Therapies Data Set,** including any appropriate anxiety disorder specific measures (ADSMs) and/or the LTC/MUS outcome measures as indicated by the problem descriptor; completion of patient experience questionnaires and presenteeism questions.
- **Socialisation to Treatment.** Most patients will be new to psychological therapy. It is therefore essential that assessors explain:
    - what treatment involves.
    - why the recommended treatment(s) are being offered (including their evidence-base).
    - the confidential nature of the therapy process.
    - a need for regular attendance and the importance of completing homework assignments.

  Scheduling of treatment sessions should consider patients' commitments at work and with family, as well as booked holidays. Patient may feel hopeless at the start of treatment, so it is important the assessor explains that Anxiety and Depression are

treatable and generates hope for the forthcoming therapy. In this way, engagement can be enhanced and early drop-out minimized.

- **Reasonable Adjustments:** Any adjustments the patient needs to engage with therapy and derive maximum benefit. For example, physical access needs to access the premises, adjustments to clinical documents to be able to read and process the information, and any adjustments relating to neurodiversity, learning disability or autism
- **Carrying out an assessment**

Assessment is a significant part of an NHS Talking Therapies clinician's role. All patients should receive an assessment with an NHS Talking Therapies clinician, which aims to clarify the main presenting problems and what needs to be focused on in treatment. It should be as efficient as possible for clinicians and as accurate as possible for patients.

Table 6 (adapted from University College London's (UCL) PWP Training Review) summarises the six key elements that form an essential part of an NHS Talking Therapies assessment, with a brief description of the outcomes for both the clinician and patient.

Table 6: Summary of six key elements of an assessment

Type of assessment	Outcome for clinician	Outcome for patient
Screening/ triage	Decision as to service eligibility and/or priority	Knows whether is accepted by service
Risk	Identification of risk and development of a safety plan (regardless of perceived level of risk)[r]	Knows the clinician has recognised potential risks and agreed a safety plan
Diagnostic: including screening for all NHS Talking Therapies conditions	Accurate problem descriptor	Knows how the problem is defined and therefore understands the rationale for treatment intervention
Psychometric: correct outcome measures including ADSMs and LTC/MUS/PPSx	Scores on measures to guide decision-making	Awareness of symptom severity and engagement with outcome measures
Problem formulation	Problem statement summary agreed with patient	Able to talk about problems, feel understood and come up with a succinct summary that helps problems feel more manageable
Treatment planning: personalised goals	Treatment goals agreed and decision as to type of treatment (based on the problem descriptor)	Has treatment goals and knows plan for treatment

[r] See NICE Guidance on Self-harm: assessment, management and preventing recurrence.

5.1.2 Establishing the appropriate problem descriptor

NICE guidance is based on the ICD. Different psychological treatment approaches are recommended for different types of problem as delineated in this framework. It is essential that assessors identify and record a problem descriptor for the main presenting problem that the clinician and patient jointly agree to work on.

Patients may have multiple problems. The NHS Talking Therapies Data Set has several problem descriptor fields that can be used in such instances. It is essential that the clinician identifies the ICD-10 code that characterises the main problem. If this is not achieved, the patient may be offered the incorrect treatment and the most appropriate outcome measures may not be used, impacting upon the patient's likelihood of sustained recovery.

Research has shown that mental health practitioners are relatively good at detecting depression but often miss anxiety disorders.

The Adult Psychiatric Morbidity Survey 2023/24 found that most people who experienced a common mental health disorder in the previous week have had their depression recognised by a mental health professional at some stage in their life. By contrast, less than a quarter of people with an anxiety disorder have ever had that condition recognised by a professional. Of course, living with a chronic anxiety problem can lead to occasional episodes of depression. Interestingly, the data show that these episodes are detected without the underlying anxiety disorder being recognised.

Clinicians who have identified that a patient is depressed should continue their assessment to determine whether there is an underlying anxiety problem that needs to be treated. If such problems are not recognised and dealt with, further episodes of depression are highly likely.

To ensure that all relevant problems are identified, it is recommended that assessments include systematic screening for ALL the conditions that NHS Talking Therapies treats (see Appendix B for screening prompts). Failure to probe for all relevant conditions can cause significant problems. Most referrals to NHS Talking Therapies services will have elevated scores on the PHQ-9 and/or Generalised Anxiety Disorder scale – 7 items (GAD-7) but this does not necessarily mean that they are suffering from clinical depression or generalized anxiety disorder. Unless the assessment probes for all NHS Talking Therapies relevant conditions, there is a risk that people will be started on the wrong treatment. This is frustrating and unhelpful for patients, can lead to them disengaging or not clinically benefitting. It also creates problems for the service as scarce resources are used inappropriately and overall outcomes are undermined, to the frustration of the hard-working team.

Avoiding inappropriate use of the mixed anxiety and depression problem descriptor

It is common for people to have an anxiety disorder and also experience an episode of depression. When both are of clinical severity, each should be correctly identified with a problem descriptor. Establishing which problem descriptor is the main one will depend on discussion with the patient, taking into account the formulation, the patient's goals and their views about what treatment should focus on, along with considerations about relative severity and disability.

The 'mixed anxiety and depression' problem descriptor (ICD-10 code) should **not** be used **unless** the patient's symptoms of depression or anxiety are both too mild to be considered a full episode of depression or an anxiety disorder. Inappropriate use of the 'mixed anxiety and depression' problem descriptor may mean that patients do not receive the correct NICE-recommended treatment. For example, if someone has PTSD and is also depressed, they

should be considered for trauma-focused CBT or EMDR as well as management of their depression, but this may not happen if they have been identified as having 'mixed anxiety and depression'.

Assessing the duration of the mental health difficulties (problem descriptor) that will be the focus of treatment

This is essential as NICE guidance may vary with problem duration. While some mental health problems seen in NHS TT services have a recent onset, for many people the problems have been going on for multiple months, years or even decades. To identify and record the onset date of the current episode assessors can ask; "*When did your [mention the problem descriptor] begin?*" and also "*Has there been a time since it began when you were free of [problem descriptor] for a substantial period (at least 3-6 months)*?. If patient answers yes, onset of the current episode recorded should be based on the date of return of symptoms.

5.1.3 Selecting the outcome measure

As part of the assessment process, it is important for the clinician to ensure the appropriate outcome measure has been selected. If the problem descriptor is linked to a particular ADSM or LTC/MUS measure it is essential that the relevant measure is given at every treatment session, in addition to the PHQ-9, GAD-7 and the Work and Social Adjustment Scale (WSAS). See Section 6.2 for details. Patient experience questionnaires (PEQs) should be used at the end of assessment and treatment, the results of which should be used to monitor and improve service delivery.

5.2 Delivering effective treatment

To ensure treatment is effective and recovery is promoted, it is an essential and core principle of the NHS Talking Therapies model that NICE-recommended treatment (see Table 2) is provided at the appropriate dose, in line with the identified problem descriptors, and that a choice of therapy is offered where appropriate. NICE recommends that for the treatment of less severe depression and some (but not all) anxiety disorders, a stepped/stratified care model for delivery of psychological therapies is used. The model has demonstrated effectiveness in delivering positive outcomes, while reducing the burden experienced by the patient in treatment.

It is important that stepped/stratified-care is used appropriately, and that treatment is provided, through consultation between the clinician and their case management supervisor, according to the following key principles (see Table 7).

Table 7: The key principles of effective treatment and stepped/stratified -care

Treatment choice should be guided by the patient's problem descriptor	NICE recommends different therapies and interventions for different types of problems. For example, there are multiple recommended HIT therapies for depression, whereas only CBT is recommended for anxiety disorders. For PTSD and significant symptoms of PTSD, trauma focussed CBT or EMDR are recommended. Even within CBT, there is a range of different protocols for different conditions. For example, trauma focussed CBT for PTSD is very different from CBT for social anxiety disorder. Within low-intensity treatments, the guided self-help materials used should be matched to the specific problem type. It is essential that clinicians work together with the patient to clearly identify the primary clinical problem that they want help with before selecting a treatment type. Where there is more than one problem, the primary problem should be determined by considering a combination of NICE-based evidence, the formulation, and the patient's goals and choices.
A NICE-recommended intervention	A range of NICE-recommended interventions should be offered (see Table 2). This includes the concurrent use of medication in moderate to severe (but not mild) depression.
Offer the least intrusive intervention first	The least intrusive NICE-recommended intervention should generally be offered first, but it is important that low-intensity interventions are only offered where there is evidence of their effectiveness. For example, a patient with more severe depression or other types of anxiety disorders, such as PTSD or social anxiety disorder, should receive a high-intensity intervention first.
Treatment should be guided by the patient's choice	When NICE recommends a range of different therapies for a particular condition being treated, and where possible, people should be offered a meaningful choice about their therapy. Where treatments are on average similarly effective, giving people their preferred treatment is associated with better outcomes. Choice should include how it is provided, where it is delivered, the type of therapy and where possible the clinician (for example, male or female).
Offer an adequate dose	All people being treated should receive an adequate dose of the treatment that is provided, in accordance with NICE guidelines. The number of sessions offered should never be restricted arbitrarily. People who do not respond to low-intensity treatments (and as such, still meet caseness) should be given at least one full dose of high-intensity treatment as well within the same episode of care.

A minimal wait	No patient should wait longer than necessary for a course of treatment. Services should work to a high-volume specification with minimal waiting times for treatment (and within national standards), as well as facilitating movement between steps (see appropriate stepping).
Appropriate stepping	A system of scheduled reviews (supported by the routine collection of outcome measures and supervision) should be in place to promote effective stepping and avoid excessive doses of therapy. This includes stepping up when there is no improvement, stepping down when a less intensive treatment becomes more appropriate or stepping out when an alternative treatment or no treatment becomes appropriate.

5.2.1 Remote delivery

The move to remote delivery at the start of the Covid-19 pandemic created many benefits for patients and clinicians, but it is vital that patients always have a choice. Remote delivery should be offered alongside in-person delivery in all areas of the country to guarantee equitable and high-quality clinical provision.

All services should facilitate informed patient choice with regards to delivery method and flex their workforce to meet changes in these choices as they occur. This choice must be informed, and not one that is effectively enforced on patients because of workforce shortages or clinical consulting room availability and associated differences in waiting times between the options offered. Waiting times for assessment and treatment should be equitable irrespective of delivery method chosen. If that is not the case, then patients are potentially being pushed into a remote delivery model because that is the only way of accessing NHS Talking Therapies quickly. This would not be a genuine informed choice.

A range of digital tools can be considered to aid both remote and in-person delivery of treatment, including psychoeducational resources and interactive homework sheets.

5.2.2 Appropriate consulting rooms and equipment

In-person sessions should be conducted in appropriate clinical consulting rooms that provide confidential space for both patients and staff to feel comfortable and for therapists/practitioners to deliver NICE recommended treatments appropriately. Space is only confidential if patients and therapists/practitioners cannot be seen or overheard from outside the room. Rooms must be large enough:

- For both patient and therapist to stand up and move within the room to conduct in-session behavioural experiments.
- For patients with a variety of needs and therapists to sit at a comfortable distance from one another
- For essential equipment to be installed and used appropriately such as whiteboards for CBT, video recording for social anxiety treatment and light bars for EMDR.
- For the inclusion of additional people in the room as required (e.g. family members, interpreters or co-therapists such as trainees observing).

5.2.3 In-person sessions outside of the consulting room

Adhering to evidence-based competences for delivering specific therapies for a range of disorders is essential to improving outcomes. Activities described within the competence frameworks ensure best practice and will include sessions outside the consulting room,

where appropriate. This can have an impact on service capacity and should be considered when commissioning NHS Talking Therapies services to ensure appropriate funding is in place for therapists to accompany patients on some out-of-office assignments (such as behavioural experiments, exposure & response prevention, revisiting the site of a trauma for patients with PTSD, etc).

Session duration can also vary depending on adjustments made to enable access and when implementing evidence-based interventions for specific anxiety disorders. For example, evidence-based protocols require that 90-minute sessions are scheduled for treatment of PTSD or Social Anxiety Disorder.

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

In contrast to most other conditions treated in NHS Talking Therapies services, NICE[13 14] does **not** recommend low intensity (step 2) therapies for PTSD or social anxiety disorder. Instead, individuals with either of these conditions should be immediately offered a course of the relevant, specialised high-intensity therapy. For PTSD, the recommendation is for either Trauma-Focussed CBT (TFCBT) or Eye Movement Desensitisation and Reprocessing (EMDR). For social anxiety disorder, the recommendation is a course of individual CBT based on either the Clark and Wells or Heimberg model. Services should ensure that they have sufficient high-intensity therapists trained in these treatments to offer them promptly. Because the treatments are specialised, it is important that the therapists benefit from supervision by senior clinicians who are themselves trained in the treatments. Services may wish to consider creating specialist PTSD and social anxiety disorder care pathways so that most cases are treated by clinicians who have a particular interest in these conditions. This can be an efficient and effective way of deploying clinical resources.

NICE has recently approved a digitally enabled therapy for social anxiety disorder and two digitally enabled therapies for PTSD. Each faithfully delivers the content of the NICE recommended high-intensity CBTs for the relevant condition and so can be offered to patients as an alternative to face-to-face therapy, if delivery is supported by a HIT who is trained in their use. These products have also been assessed against the Digitally Enabled Therapies Assessment Criteria.

Services should monitor waiting times for NICE-recommended treatment of PTSD and social anxiety disorder and take appropriate action if these are excessive. Longer waiting times may be due to a shortage of appropriate staff. A less than complete initial assessment can also lead to excessive waits.

PTSD is just one of the many mental health conditions that can be triggered by a traumatic event. It is therefore important that services do not put an individual on a waiting list for PTSD treatment just because a trauma is reported at assessment. In such instances, it is wise to screen for PTSD using the full PCL-5 or a validated short version[15] .If the individual screens positive, follow-up questions should be used to confirm PTSD, or significant symptoms of PTSD, and that it is the main problem requiring treatment. See Treatment of Post Traumatic Stress Disorder including Complex Post Traumatic Stress Disorder: Guidance for delivery of psychological therapies.

Similarly, if social anxiety disorder is suspected, screening with the Social Phobia Inventory (SPIN) or the 3-item Mini-SPIN[16] followed by appropriate follow-up questions is recommended. Assessors should be aware that the extensive avoidance of feared situations that can occur in social anxiety disorder means that a sizeable proportion of patients who score above threshold on the SPIN and are disabled by the condition will score below threshold on the GAD-7 at assessment. This should not be a reason for withholding the appropriate high-intensity therapy and reiterates the importance of using an ADSM. Video

feedback is a central procedure in the treatment of social anxiety disorder so services should make suitable equipment available.

The NICE-recommended forms of TFCBT for PTSD and CBT for social anxiety disorder both require therapists to conduct some sessions out of the consulting room (revisiting the site of the trauma, some behavioural experiments). Services should make provision for this work and also ensure that longer sessions (up to 90 minutes) are scheduled when required (for example, for behavioural experiments or trauma memory work). Longer sessions (up to 90 minutes) are also recommended for the trauma confrontation phases of EMDR (Phases 3-6). On average, treatment of PTSD is likely to require more sessions for patients who have experienced multiple traumas than those with a single trauma. Multiple traumas (including childhood traumas, military trauma, or traumas experienced because of forced migration) should not automatically exclude a patient from treatment within NHS Talking Therapies.

High-intensity therapists who wish to further develop their skills can find illustrative videos on PTSD with TFCBT assessment, and key manoeuvres for treating PTSD and social anxiety disorder at oxcadatresources.com.

6 The importance of data: monitoring clinical outcomes and activity

A key characteristic of the NHS Talking Therapies for anxiety and depression programme is the routine collection of clinical outcome measures and monitoring of activity. The introduction of session-by-session outcome measures has had an important impact on mental health services.

Prior to NHS Talking Therapies, most psychological therapy services only aimed to collect measures of symptoms and disability at the beginning and end of treatment. As patients do not always finish therapy when expected and clinicians were not in the habit of regularly giving outcome measures, this meant that post-treatment outcome data were missing for a large number of treated patients. This impacts directly on data available to drive service improvement. Subsequent research showed that this also led to services being likely to overestimate their effectiveness because individuals who did not provide post-treatment scores tended to have done less well.[17]

NHS Talking Therapies has addressed this problem by measuring symptoms at every session. In this way, if a patient completes treatment earlier than expected, or a clinician forgets to deliver the measure on a particular occasion, there is always a last available score that can be used to assess outcome. Adoption of the session-by-session outcome monitoring system has enabled NHS Talking Therapies services to obtain outcome data on 98.5% of all patients who have a course of treatment.

Data are collected to:

- **Ensure equitable use of NHS Talking Therapies services.** Demographic information on statutorily protected characteristics should be used to monitor and actively address any barriers to service provision. Where possible socio-economic status can also be used to monitor and address barriers service provision.
- **Monitor and support the delivery of NICE-recommended care**. This includes helping to ensure that treatments are being delivered in a manner that is most likely to be clinically effective (for example, adequate number of sessions, short waiting times).
- **Provide information to the clinician.** This will help identify appropriate targets for intervention in future therapy sessions (for example, suicidal thoughts, avoidance behaviours, intrusive memories, and so on).
- **Help people to track their progress towards recovery**. People have reported that they value seeing their scores from completed clinical outcome measures, and how their scores change over time. Therefore, it is important that each patient using NHS Talking Therapies services is given this opportunity. As well as helping the patient to understand more about their condition, outcomes can support the development of the therapeutic relationship and help to show improvement.
- **Enhance engagement in collaborative decision-making and treatment reviews**. In combination with person-centred care, outcome measurement tools are essential for informing the continuing appropriateness of the chosen treatment and managing the therapy process (including deciding if a different step or intervention is required).
- **Support supervision**. NHS Talking Therapies recommends the use of outcomes-focused supervision. During a session the clinician and their supervisor will carefully review the outcome measures, including individual items to assess progress, identify points when the patient becomes ‘stuck’ and plan future sessions.
- **Enhance the overall quality and cost-effectiveness of services.** Services can use an outcomes framework to monitor their performance and engage in constructive

discussions to improve service quality, value for money and outcomes. Local, regional and national leads will also benefit from having accurate, comprehensive outcome data to inform policymaking.

- **To monitor the changes to employment status, sickness status and presenteeism** to inform patients, clinicians, and employment advisers of progress towards patients' employment goals

To facilitate the sharing of outcome scores to realise this broad range of benefits, services should ensure that all NHS Talking Therapies clinicians have access to up-to-date dashboards showing the patient's progress through the care pathway.

6.1 Collection of routine outcome measures

All NHS Talking Therapies services collect the NHS Talking Therapies Data Set (formerly known as the IAPT data set[s]). These data flow monthly to NHS England for analysis and national reporting. It is each clinician's responsibility to ensure that the patient's progress through the NHS Talking Therapies care pathway is recorded.

It is good practice to ask patients to complete outcome measures before the start of a clinical session; this ensures best use of clinical time. On some occasions, the clinician may want the patient to complete measures within sessions, to introduce and engage them in the process of objective measurement of symptoms. In either case, there should be discussion of and feedback on measures in the session, and use of these in shaping treatment.

The increasing availability of online portals for questionnaires means that many patients are now able to enter their data via the internet before a session with their clinician. This practice is strongly recommended. Some IT providers have made it possible for patients to enter their data using a link in a text message from the service.

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

All NHS Talking Therapies services are expected to have IT systems that support the collection and reporting of the data set. The systems should allow patients, clinicians, and supervisors to view graphical plots of progress during sessions, as well as enabling detailed reporting and analysis. Automatic flowing of data to NHS England on a monthly basis is also required.

6.2 NHS Talking Therapies outcome measures

The NHS Talking Therapies Data Set is intended to be used on a session-by-session basis for all individuals receiving treatment in NHS Talking Therapies services. It includes measures of **symptoms, disability, and employment**.

The symptom measures that are recommended depend on the clinical condition that is being treated (problem descriptor), see Table 8.

Table 9 indicates the clinical cut-offs and reliable change index for each measure.

[s] The data set will continue to be referred to as IAPT until the next uplift of the data set has received Data Alliance Partnership Board (DAPB) approval, expected in 2024.

The main measure of disability is the WSAS, which assesses the extent to which a patient's mental health problem interferes with their functioning at work, at home, at leisure, socially and with their family. Although disability often decreases as symptoms improve, that is not always the case. For this reason, clinicians need to carefully monitor WSAS scores as well as symptom scores to ensure that people have minimal disability once treatment is finished.

Table 8: NHS Talking Therapies outcome measures by problem descriptor

		Required Measure			
	Main mental health problem (primary presenting complaint)	**Depression symptoms**	**Anxiety symptoms or MUS**	**Further option***	**Measure of disability**
Depression	Depression	**Patient Health Questionnaire (PHQ-9)**	**Generalised Anxiety Disorder – 7 (GAD-7)**	Generalised Anxiety Disorder – 7 (GAD-7)	Work and Social Adjustment Scale (WSAS)
Anxiety	Generalised anxiety disorder				
	Mixed anxiety/ depression				
	Chronic pain (in context of anxiety/ depression)				
	Specific phobias **				
	Agoraphobia		**Mobility Inventory (MI)**		
	Health anxiety (hypochondriasis)		**Health Anxiety Inventory (HAI)**		
	OCD		**Obsessive-Compulsive Inventory (OCI)**[t]		
	Panic disorder		**Panic Disorder Severity Scale (PDSS)**		
	PTSD		**PTSD Checklist for DSM-5 (PCL-5)**		
	Social anxiety		**Social Phobia Inventory (SPIN)**		
	Body dysmorphic disorder (BDD)		**Body Image Questionnaire (BIQ) Weekly**		

[t] The OCI will be replaced with the shorter OCI-R in the near future. Both measures include subscales for different subtypes of OCD (checking, washing, mentalising etc). Some patients who are significantly impaired will have initial scores below the clinical cut-off for the total scale. These individuals should still be offered treatment if they show significant clinical problems within a subscale (for example an average score of 2.5 or above on at least one subscale).

Medically Unexplained Symptoms	Chronic fatigue syndrome		**Chalder Fatigue Questionnaire (CFQ)**		
	Irritable bowel syndrome (IBS)		**Francis Irritable Bowel Syndrome (IBS) scale**		
	MUS not otherwise specified		**Patient Health Questionnaire – 15 (PHQ-15)**		
***Further option is only used if 'recommended measure for anxiety symptoms or MUS' is missing.					
**Testing currently taking place on outcome measure for specific phobias. This measure will be introduced when assured.					
Note: Recovery, reliable improvement, reliable recovery, 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.					

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

Table 9: Clinical cut-offs and reliable change index

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

[u] The OCI will be replaced with the shorter OCI-R in the near future. The caseness value for OCI-R is 21 or above. The reliable change value is 10 or above. Both measures include subscales for different subtypes of OCD (checking, washing, mentalising etc). Some patients who are significantly impaired will have initial scores below the clinical cut-off for the total scale. These individuals should still be offered treatment if they show significant clinical problems within a subscale (for example an average score of 2.5 or above on at least one subscale).

6.2.1 Anxiety Disorder Specific Measures

Most people who are seen in NHS Talking Therapies services report significant levels of both depressive and anxiety-related symptoms. For this reason, patients are asked to complete measures of both at every session. The PHQ-9 is used as the depression measure for all patients. The GAD-7 is the default measure for anxiety. This scale was originally developed to assess the severity of anxiety symptoms in generalised anxiety disorder only. Patients with other anxiety disorders often also show elevated scores on the GAD-7 and it has come to be used as a measure of change in these conditions as well. However, this has a marked disadvantage in that it does not cover key symptoms that should be targeted in therapy for particular anxiety disorders. The omitted symptoms include:

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

Given these omissions, NHS Talking Therapies guidance recommends that clinicians also administer a well validated measure that is specific to the symptoms of these disorders, if they are the focus of treatment. This ensures that clinicians can focus on relieving the symptoms that cause the patient most distress.

Inspection of item-by-item responses on ADSMs can be particularly informative. For example, the PCL-5 is used to monitor progress in PTSD. Some items on this scale measure intrusive memories and others measure avoidance of reminders. If a patient shows a reduction in the frequency of intrusive memories the clinician will want to check that the reduction is a genuine improvement rather than a result of more avoidance. In the latter case, the clinician would need to focus the next few sessions on overcoming avoidance.

Similarly, the SPIN can detect disabling social anxiety in patients who score near or below the clinical cut-offs on the GAD-7 and PHQ-9. Regular use of the SPIN with such patients will help ensure they get the right treatment and that it continues long-enough to promote full recovery, even if GAD-7/ PHQ-9 scores are already below threshold.

NHSE uses the PHQ-9 and the relevant ADSM to calculate recovery and reliable improvement, when matched with the problem descriptor. With NHS Talking Therapies-LTC services this is now extended to the PHQ-15, the Francis IBS Scale and the CFQ. If these additional measures are missing, recovery is calculated using the PHQ-9 and the GAD-7.

Recent analyses of the NHS Talking Therapies database have shown that when therapists use the relevant ADSM to guide the treatment of people with PTSD, social anxiety disorder, panic disorder and obsessive-compulsive disorder, clinical outcomes are better, and patients report a greater reduction in mental health related disability (assessed by the Work and Social Adjustment Scale). This beneficial effect is thought to be because regular administration of ADSMs helps therapists to keep a strong focus on the key features of the relevant clinical condition.

6.2.2 NHS Talking Therapies Long-Term Condition and Medically Unexplained Symptoms/ Persistent Physical Symptoms outcome measures

The following briefly describes and lists the LTC/MUS outcome measures:

- **Mental health outcomes:** a primary outcome that will be used to calculate recovery, based on paired outcomes for:
    - PHQ-9, **and**
    - GAD-7 or an ADSM or a MUS/PPSx measure (Francis IBS Scale, CFQ or PHQ-15[v]), as appropriate.

- **Perception of physical health:** it is important to measure a patient's perception of how their LTC impacts on their overall functioning and how this might change over the course of treatment. Helpful measures for particular LTCs are:
    - Diabetes Distress Screening Scale
    - COPD Assessment Test (CAT)
    - Brief Pain Inventory.

6.2.3 Patient experience questionnaires (PEQs)

It is important that patients have an opportunity to comment on the quality of their care and shape service improvement. PEQs are specifically designed to provide this opportunity. Services are encouraged to give all patients the Assessment PEQ at the end of their assessment contact and the Treatment PEQ at the end of their course of treatment. It is important that these are administered in a way that ensures that patient responses are confidential, so that their responses are a true reflection of their experience.

In addition to confidential completion of the PEQ, clinicians should facilitate a relationship where patients feel sufficiently confident to voice any concerns about the progress of treatment within their sessions.

6.2.4 Employment metrics

It is the responsibility of both clinicians and employment advisers to collect employment data at every session. Collection of employment status and benefit status allow changes in employment between the start and end of treatment to be tracked e.g. whether people stay in employment, find employment or become unemployed. Collection of sickness status enables tracking of whether people are returning to work from sickness absence. The productivity questionnaire tracks the level of presenteeism as a measure of increased productivity.

6.3 Data quality

It is the responsibility of all NHS Talking Therapies workers to enter timely and accurate information and scores for each patient and each appointment session (whether this session is an assessment or treatment, and whether a patient is immediately discharged or goes on to have a course of treatment). Commissioners and providers should ensure that robust data

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

quality and information governance processes are in place and that staff receive the appropriate training to ensure ongoing adherence. This includes adherence to technical guidance, the correct way to capture referral dates (the date the referral is received) and what constitutes 'entering treatment' to ensure that national reports accurately represent the provider's key performance metrics.

6.3.1 Paired-data completeness

> High levels of session-by-session data completeness are essential for improving service quality and effectiveness. NHS Talking Therapies requires a minimum of 95% data completeness for pre/ post-treatment scores from all clinical contacts.

Data completeness is critical for:

- delivery of NICE-recommended treatment
- effective clinical governance
- enhanced patient experience
- local and national service evaluation.

6.3.2 Missing data

Missing outcome data may be caused by several factors, including the patient's distress or objection to its collection, language or reading barriers, perceived administrative burden and a lack of understanding of the importance of collecting data. This should be addressed where possible, so that people who leave treatment in an unscheduled manner will have some evidence of their progress before they leave the service.

When outcome data are not collected in every session, this can mean that end of treatment scores are unavailable. Missing end of treatment scores can lead services to overestimate their effectiveness as people whose scores are missing tend to have improved less.[18] People may also exercise their right to refuse to provide the information requested at any time. However, a mutually acceptable and effective therapeutic relationship can help to encourage data submission.

6.3.3 Data collection for couple therapy

It is important to consider whether the non-referred partner is also experiencing depression and/or anxiety. On occasion the non-referred partner may have poorer scores than the referred partner.

For Couple Therapy for Depression (CTfD) and Behavioural Couple Therapy (BCT), services should record data for both partners. Each should have a separate health record, irrespective of the non-referred partners' outcome measure scores. A problem descriptor should be recorded if identified and updated as appropriate.

6.4 National standards

Autumn Statement 2023 Settlement (2024/5 – 2028/29)

From 1st April 2024, the national standards for NHS Talking Therapies services are:

1. Number of people receiving a course of treatment (at least two sessions) to increase to 915,000 per annum by the end of 2028-29.

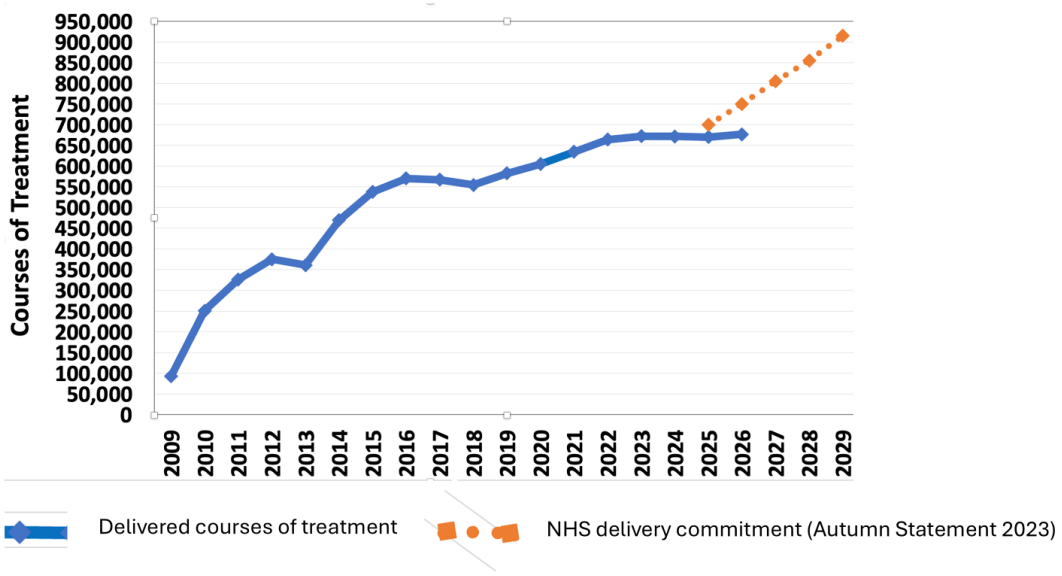
2. Maintaining existing waiting time standards; of the referrals that have a course of treatment (two or more clinical sessions), at least 75% should have their first session within six weeks, and 95% within 18 weeks.
3. Proportion of people achieving reliable recovery; 53% of patients achieving reliable recovery following a course of treatment by 28/29.
4. Proportion of people achieving reliable improvement; 71% of patients achieving reliable improvement following a course of treatment by 2028/29.

Depression and anxiety can hold people back in many areas of life. Following the investment in the Autumn Statement, the NHS Talking Therapies programme is shifting emphasis to focus on providing courses of treatment (i.e. 2 or more contacts), alongside increasing the number of sessions individuals receive to improve recovery rates.

The extra ring-fenced funding of £592,000 for NHS Talking Therapies, from 2024/25 is aimed at helping more people recover from anxiety and depression. It will do this by increasing the size of the clinical workforce over 5 years, enabling more people to have a course of treatment and supporting services to offer patients a larger number of sessions, which will improve people's chance of fully recovering.

Figure 4 shows the planned trajectory for expanding courses of treatment with the additional investment, alongside delivered courses of treatment.

Figure 4: Courses of treatment (commitment and delivered)



The previous NHS Talking Therapies access metric (enacted in the NHS Long Term Plan) enabled record levels of referrals and numbers of individuals engaging with NHS Talking Therapies, however many individuals are not accessing a course of treatment, in part due to levels of inappropriate referrals. The service rebrand from IAPT to NHS Talking Therapies, the communications campaign in Q4 2023/24, and closer alignment with community mental health and primary care has started to adjust that balance. This effect will be amplified by the extra investment.

Through the investment, there will be a focus on increasing the high-intensity to low-intensity therapist ratio and helping to reduce "within pathway" waits affecting high-intensity therapy that can be a deterrent to referral of appropriate and more severe referrals. Moving the ratio of low:high-intensity therapists to a more suitable level, in line with NICE recommended care and to meet the needs of those accessing the service, will enable services to deliver high-intensity therapy without an excessive wait and thus have a positive impact on outcomes.

The investment outlined in the Autumn Statement increases year on year. Activity growth standards will be provided annually via the NHS England Operating Planning Guidance. Workforce growth at a local level will also need to increase year on year in line with investment.

The NHS Talking Therapies Data Set includes the national standards alongside a large number of other measures that together provide clinicians, commissioners and patients with a comprehensive picture of how a service is performing. Stakeholders should look at the full range of measures to get a clear idea of the strengths of a service and the areas of focus to enhance further improvement. Two public websites display ICB service-level data. These are:

- NHS England's reports from NHS Talking Therapies
- Office for Health Improvement & Disparities' Common Mental Health Disorders Profiles Tool

6.4.1 Courses of treatment

A patient is deemed to have had a '**course of treatment**' in NHS Talking Therapies if they have had at least two clinical sessions (coded as 'assessment and treatment' and/or 'treatment') before discharge.

NICE-recommended treatment should be appropriate to the patient's problem, and patients should have a choice of appropriate treatments and mode of delivery where possible. For most problems, a 'stepped care' model is used. This means that many people with mild to moderate anxiety disorders or depression are offered lower-intensity therapies at first, and 'stepped up' to higher-intensity therapies if they do not respond to the initial treatment. People with more severe depression/anxiety may receive higher-intensity therapies from the beginning of treatment. Everyone with PTSD or Social Anxiety Disorder should be offered high-intensity therapy. This matching of presentation to high-intensity therapy from the beginning in these cases is known as 'stratified care'.

It is important that the '**treatment**' code is only used when a significant portion of a session is devoted to delivering an appropriate psychological intervention that is supported in NHS Talking Therapies.[18]

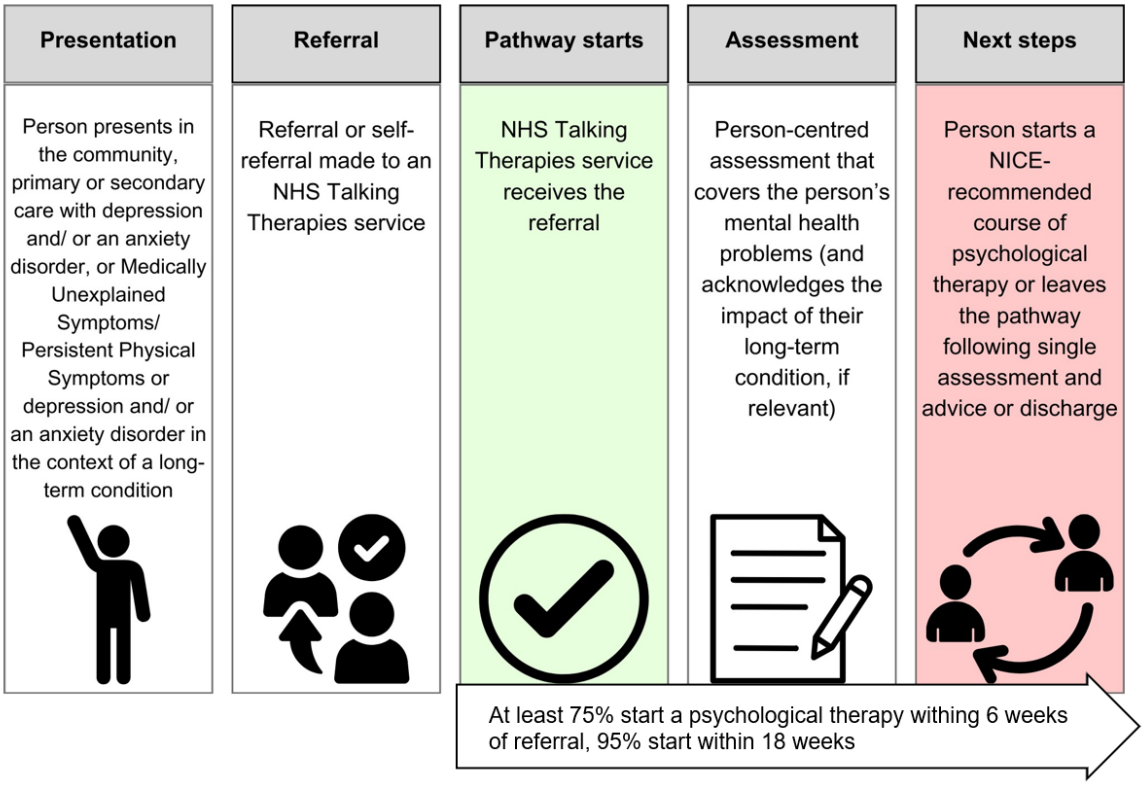
It is important that the number of people receiving a course of treatment is closely monitored (using 'courses of treatment'/ 'finished treatment' metric) to ensure appropriate balance between single-session assessments of mental health difficulties and courses of treatment (two or more sessions) for the clinical conditions covered by the NHS Talking Therapies programme. The ambition is for at least 60% of those who receive an assessment in an NHS Talking Therapies service to go on to have a course of treatment. Achieving this ambition will require local clarity about the mental health problems treated in NHS Talking Therapies services and close liaison between services, primary care, and community mental health.

6.4.2 Waiting times standard

The national waiting time standard for the NHS Talking Therapies programme refers to the period of time between the date that an initial referral was received and the first session (which is primarily assessment). Of the referrals that have a course of treatment (two or more clinical sessions), at least 75% should have their first session within six weeks, and 95% within 18 weeks. This minimum standard has been established because there is good evidence that patients are more likely to benefit from a course of treatment if it is delivered promptly. It is expected that once a patient has been accepted for treatment following the initial assessment session, the treatment should start promptly. To ensure this is the case, NHS England also publishes data on the wait between first and second session. From a patient point of view, the wait between referral and the second session is particularly important because this is effectively how long they wait before starting treatment proper.

A summary of the mental healthcare pathway for NHS Talking Therapies services is set out in figure 5.

Figure 5: Pathway for NHS Talking Therapies services



It is good practice for the waiting time standard to be applied to each of the initial interventions (low-intensity and high-intensity therapies) that are offered during a course of treatment. Services should guard against in-service pathway waits within a course of treatment. This means that once a service has offered an individual a course of treatment, the whole care episode should progress in a timely fashion, including gaps between sessions within a step, and also gaps between steps.

Waits for high-intensity therapy should not be substantially longer than waits for low-intensity therapy.

Information on waiting times, including in-pathway waits, for the NHS Talking Therapies programme is published by NHS England on a monthly, quarterly and annual basis.

6.4.3 Clinical outcomes

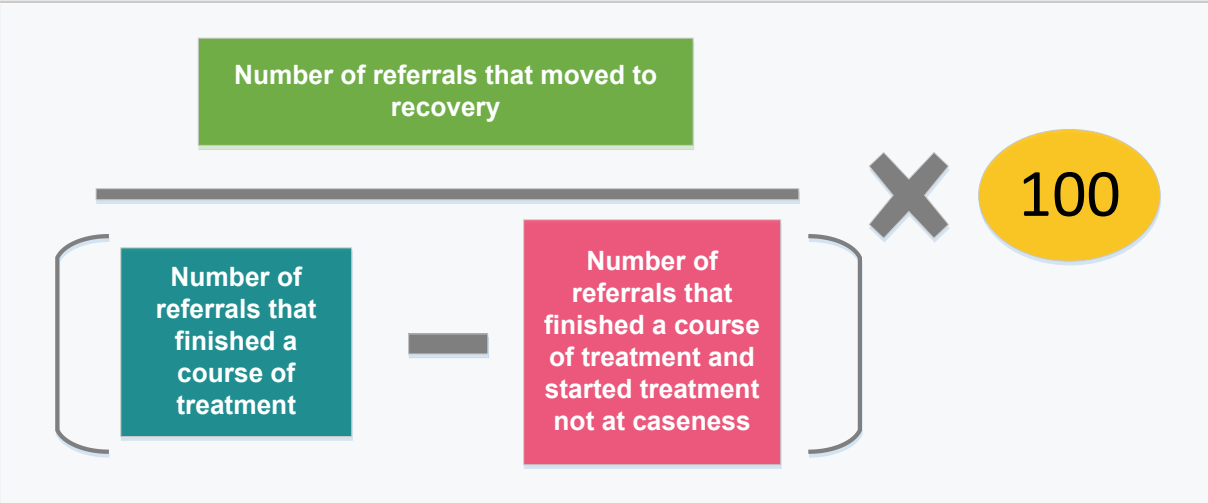
Recovery rate

Recovery is measured in terms of 'caseness' – a term which means a referred patient has symptoms of depression or anxiety that exceed a defined threshold, as measured by data set outcome measures (including the appropriate ADSM or MUS measure; see Table 8).

A patient is considered recovered if their scores on the depression and/or the relevant anxiety/ MUS measure are above the clinical cut-off on **either measure** at the start of treatment, and their scores on **both measures** are below the clinical cut-off at the end of treatment. NHS Talking Therapies operates a policy of only claiming demonstrated recovery. This means that the small number of patients who have missing post-treatment data are coded as having not recovered.

Recovery rates are calculated based on paired-data outcomes for both the depression (PHQ-9) and the relevant anxiety or MUS measure (see Section 6.2). It is critically important to ensure complete and accurate problem descriptors paired with the correct disorder specific measure, so that these can be counted in the recovery rate calculation (see Figure 6).

Figure 6: Recovery rate calculation



Reliable improvement

Many people who receive a course of treatment improve significantly, even if they do not fully recover. In addition, some may move out of 'caseness' through minimal improvement. For these reasons it is important to track and maximise improvement as well as recovery. A patient has shown reliable improvement if their scores on the depression and/or the relevant anxiety/ MUS measure have reduced by a reliable amount and neither measure has shown a reliable increase. The reliable improvement calculation applies to everyone who has a course of treatment irrespective of whether they meet caseness criteria at the start of treatment.

Reliable recovery

A patient has ‘reliably recovered’ if they meet the criteria for both recovery and reliable improvement. Reliable recovery replaced recovery as a key KPI in 2023.

6.4.4 Taking a broader perspective

The NHS Talking Therapies national standards are not a goal in themselves. It is important for commissioners and providers to remember that the standards are simply aids to help services provide timely and effective treatment that transforms people's lives.

Consideration of the full range of NHS Talking Therapies measures (symptoms, disability, employment, and patient experience) is the most appropriate way to determine whether our aspirations for timely and effective treatment have been achieved.

In some instances, consideration of the full range of NHS Talking Therapies measures may suggest that treatment should continue even when PHQ-9 and GAD-7/ ADSM/ MUS scores have dropped to a low level. For example, if inspection of the WSAS reveals that a significant degree of interference with everyday functioning is still present, further sessions with an emphasis on functioning may be required. Similarly, if a patient has been out of work because of a mental health problem and would like to re-join the workforce, further work in collaboration with an employment adviser may be required. NICE also recommends that a course of treatment includes relapse prevention work, which may continue after reaching the recovery threshold.

Services should ensure that changes to practice are fully in the interest of providing effective treatment, and do not just aim to improve performance on national standards.

Examples of practices that may appear to improve individual metrics but are **not** beneficial for patients include:

- Refocusing service provision on patients with less severe depression and anxiety disorders.
- Increasing the use of single session assessment and intervention at the cost of reducing staff capacity to deliver courses of treatment (two or more therapy sessions).
- Only providing single session workshops after an assessment interview, to technically qualify for giving a course of treatment.
- Providing treatment in groups, primarily to increase the number of people who are counted as having a course of treatment, when there is not a strong empirical case for using group treatment.
- Immediately discharging patients when they get to the recovery threshold (rather than ensuring that they have learned enough to stay well, and a relapse prevention programme is in place).
- Not providing an assessment to individuals for whom it is unclear whether a course of treatment in the service is appropriate. For some individuals, simple advice and signposting may be clinically appropriate.

Access

Access is a count of everyone who attends at least one clinical appointment on a one-to-one basis, has an assessment, is given advice and psychoeducation, and is either signposted elsewhere or offered a multi-session course of NHS Talking Therapies treatment. A patient is coded as having 'accessed NHS Talking Therapies' if at least one session (on a one-to-one basis) is recorded as either 'assessment and treatment' or 'treatment'.

NHS Talking Therapies services should offer a one-to-one person-centred assessment that provides the patient with information about the service, identifies the patient's problem(s) and suitability for the service, and determines the appropriate NICE-recommended treatment. Some problems are best treated elsewhere in the NHS or with other help (such as debt or housing advice), in which case patients are signposted to the relevant service. When problems are very mild, a good assessment and advice may be all that is required.

In the NHS Talking Therapies data set clinicians can select three different terms to describe the type of initial appointment. These are:

- assessment
- assessment and treatment
- treatment.

Patients whose problems are likely to benefit from a course of NHS Talking Therapies treatment will have a series of appointments with the service.

It is important that the '**assessment and treatment**' code is only used when a significant portion of a session is devoted to delivering an appropriate psychological intervention that is supported in NHS Talking Therapies.[18]

Services should develop written criteria for deciding whether an initial session can be coded by their staff as '**assessment**' or as '**assessment and treatment**'. Generally, sessions that exclusively focus on assessment or very brief sessions that simply identify that NHS Talking Therapies is not appropriate for an individual should be coded as '**assessment**'. However, if any of a range of recognised interventions[18] are a significant focus of the session, it would be appropriate to use the '**assessment and treatment**' code. Examples of such interventions include (but are not restricted to): psychoeducation, provision of self-help materials, presenting the rationale for a course of treatment that will start in the next session, and introducing a digital treatment.

Referrals

To ensure that services are delivering clinically effective interventions to patients who require a course of NHS Talking Therapies treatment, the number of eligible referrals should be monitored. Without sufficient numbers of eligible referrals, other key metrics cannot be met.

Flow through the service pathway

The rate of patients dropping out prior to first appointment and patients discharged after the first session, rather than going on to have a full course of treatment, should be monitored in order to identify issues and determine actions required to maximise seamless flow from referral to treatment for individuals whose clinical problems fall within the remit of NHS Talking Therapies services.

Reliable deterioration

Psychological therapies have the potential to do harm as well as good. For this reason, it is essential that commissioners and providers also monitor whether patients have deteriorated during the course of treatment. A patient is considered to have reliably deteriorated if their scores on the depression and/or the relevant anxiety/ MUS measure have increased by a reliable amount and neither measure has shown a reliable decrease. The fluctuating nature of mental health problems means that some reliable deterioration may be expected in the natural course of events, but abnormally high deterioration rates should be investigated. See Appendix D.

6.5 National and regional reports

NHS England provides national and local (ICB and provider level) aggregate reports based on data extracts submitted each month to the central reporting system. Monthly, quarterly, and annual reports are published. These reports include summary information relating to:

- **Courses of treatment**: the number of patients who receive at least two clinical sessions before discharge.
- **Effectiveness:** the pattern of outcomes (symptoms, mental health related disability, and employment), the variability of outcomes within and between services, and the relationship of these to presenting problems and medication usage. In addition to the standard metrics of recovery, reliable recovery, reliable improvement and reliable deterioration, the annual report also includes pre- and post-treatment means and standard deviations for all outcome measures, plus effect sizes.
- **Access**: the number of patients who receive NHS Talking Therapies-recognised assessment, advice and signposting or start a course of NHS Talking Therapies treatment in relation to patient demographic details and clinical condition.
- **Efficiency**: the pattern and duration of interventions, including waiting times, patient flow through the care pathway, Did Not Attends, cancelled appointments, and the frequency of movement between steps, presented in terms of patient demographic details.
- **Data completeness:** the proportion of patients who provide complete data on key access criteria, the proportion of patients who receive treatment and for whom treatment scores are available at both pre- and post-treatment.

Services should not regard central reports as a substitute for local reporting capability. Service data leads are vital in supporting the reporting needs of service managers, supervisors, and NHS Talking Therapies workers. Data will require regular validation and local data quality checks will be key to the robustness and reliability of the reporting system. Commissioners are held to account for providers' performance based on national not local reports, therefore services must ensure that local and national data are aligned.

Further information on the NHS Talking Therapies data set can be found on the Office for Health Improvement and Disparities Mental Health Disorders Profiling Tool.

7 Getting better results: improving access to high-quality services

7.1 Expanding the workforce

The growth of the NHS Talking Therapies for anxiety and depression workforce is a key driver in achieving our ambition to see and treat many more patients each year. This will only be possible if systems and services continue to plan for a substantial expansion of the workforce, in line with indicative workforce modelling generated nationally. To ensure the quality of NHS Talking Therapies provision, it is vital that the skill mix of the workforce is appropriate, meets the needs of the local population and provides meaningful patient choice.

Over recent years, workforce expansion has become more and more focused on trainee numbers rather than the overall number of established posts in services. Whilst training is a key element of expansion, we need to shift our thinking to focus on the overall number of posts and include recruitment of qualified staff who join the NHS Talking Therapies workforce alongside trainees, as well as including all Step 3 modality therapies in the overall high-intensity Therapist (HIT) trainee expansion. As well as expanding through recruitment of PWP and HIT CBT trainees, services can also expand by:

- Recruiting suitably qualified staff as HIT trainees to undertake a range of approved modality trainings, with automatic progression to qualified posts on completion of the training.
- Recruiting staff with a recognised NHS Talking Therapies qualification from outside of NHS Talking Therapies (e.g. qualified clinical psychologists with BABCP accreditation)

The expansion of the workforce also relies on maximising rates of retention within the service.

Workforce skill mix includes the ratio of Psychological Wellbeing Practitioner (PWP) to HITs as well as the make-up of these HITs. All systems should be working to a PWP:HIT ratio of 40:60 (core) and 30:70 (LTC). This can be averaged to a 35:65 ratio if a system is looking to achieve a combination or core and LTC.

7.2 Ways to access NHS Talking Therapies

When depression or an anxiety disorder is suspected, there are a range of access routes available into NHS Talking Therapies services. In addition to referrals being made from primary care and other healthcare professionals, NHS Talking Therapies services also accept self-referrals. This enables patients with depression or anxiety disorders to contact services directly.

The benefits to self-referral include:

- **Greater equality of access:** ethnicity of patients who self-referral is more likely to be representative of the local population.
- **Improved clinical reach:** under-represented clinical conditions (such as PTSD, social anxiety disorder and OCD) are more common among self-referrals.
- **Faster treatment response:** self-referrals tend to require fewer sessions.

7.3 Best practice

7.3.1 Improving access

There are a number of ways in which systems and providers can work to improve the identification rates of depression and anxiety disorders, as well as make NHS Talking Therapies services more accessible to the wider community.

Step 1: Increasing identification rates

Depression and anxiety disorders often go undiagnosed in primary care. There are a number of ways in which identification rates can be improved:

- Increase mental health awareness and reduce the stigma associated with mental health problems through promotional campaigns and identification of champions within the wider system, including patients and carers.
- Place a strong emphasis on the recognition of mental health problems: NICE recommends that healthcare professionals should be alert to the possible signs of depression or anxiety disorders in 'at risk' individuals and consider using a screening tool where appropriate.[20] This could include the Whooley Questions, Generalised Anxiety Disorder scale – 2 items (GAD-2) or Mini-Social Phobia Inventory Scale (see Appendix H).
- Education and training on mental health delivered to multidisciplinary teams.

Step 2: Increasing awareness of NHS Talking Therapies services and promoting self-referrals

Professionals and the public need clear and accessible information about how to access local NHS Talking Therapies services and the range of choice available. This is particularly important to promote self-referral, improve appropriate access and address the fact that anxiety disorders are commonly under-detected (see Section 5.1.2). This can be achieved in several ways, including:

- Promoting NHS Talking Therapies services using clear, accessible and engaging materials distributed in GP practices, job centres, and other community and public places.
- Having clear and informative websites that describe ways in which the service can be accessed, the problems they treat and the treatments they offer, including links to NHS Choices – conditions and treatments.
- Creating links with local services, such as housing and homeless services, financial support services, Citizens Advice, Job Centre Plus, Work Well and Connect to work
- Making links with local third sector and charitable organisations for specific under-represented groups, such as Age UK.,
- Co-location in primary care and within physical health pathways in addition to delivering services from multiple community locations.
- Use of technology, such as:
    - Engaging with the community and voluntary sector social media networks to reach high volumes of patients,
    - Appealing to different communication and learning preferences by using video clips and animations,
    - Offering online booking via the service website,
    - Text messages or mail drops from GP practices to relevant patient cohorts about NHS Talking Therapies.

Step 3: Use of digitally enabled therapy

Digitally enabled therapy (DET) is psychological therapy whereby much of the clinical content is provided via the internet, allowing much of the learning to be achieved through patient self-study which is reinforced and supported by regular support from an appropriately trained NHS Talking Therapies clinician. There is evidence to show that these therapies can achieve comparable outcomes to face-to-face therapy when the same therapy content is delivered in an online format. Many patients prefer to access therapy in this way and have become more accustomed to remote options since the COVID pandemic. It can enable clinicians to support more patients in the same amount of time.

As well as maximising the geographic reach of the NHS Talking Therapies programme, DETs can be accessed at a place and time that is convenient for the patient. They can promote access to treatment for patients who may be less likely to engage with more traditional therapy delivery methods. That might be for practical scheduling reasons (child care, being a carer, transport etc) or for emotional reasons (shame, perceived stigma, feeling self-conscious in the presence of a therapist). DETs often also have rich multi-media content, experiential exercises and mobile phone access which can be more engaging than traditional self-help booklets.

Multiple DETs are now available. Services should aim to offer patients choice of a DET where there are available products that have been shown to be at least as effective as non-digital therapies. NHS England's Digitally Enabled Therapy assessment criteria are designed to support commissioners' decision making in this area. NICE have also issued Early Value Assessments (EVAs) that recommend various DETs for use in the treatment anxiety disorders and depression in NHS Talking Therapy Services. Finally, general guidance on using digital tools across NHS Talking Therapy pathways is available via the FutureNHS platform.

DETs can support improved access to services, however, a course of treatment must only be started following the completion of a clinician-led NHS Talking Therapies assessment with an appropriately trained clinician. Treatment with a DET should also be a shared decision with patients. This is so that individuals can be offered a range of treatments which are appropriate to their problem-descriptor, needs and preferences. Services should only use digital products that operate in line with current NHS and other national policy.

8 Getting better clinical results: reducing waiting times

The national waiting time standard for the NHS Talking Therapies programme refers to the period of time between the date that an initial referral was received and the first session (which is primarily assessment).

Of the referrals that have a course of treatment (two or more clinical sessions), 75% should have their first session within six weeks, and 95% within 18 weeks.

The intention of this target is to ensure that no patient waits longer than necessary for a course of treatment. It is expected that once a patient has been accepted for treatment following the initial assessment session, the treatment should start promptly. To ensure this is the case, NHS England also publishes data on the wait between first and second session. From a patient point of view, the wait between referral and the second session is particularly important because this is effectively how long they wait before starting treatment proper.

Pauses will not be taken into consideration when calculating waiting times; instead, the national targets have built-in tolerances to offset this activity (that is, 75% and 95%).

A number of additional measures are captured in national reports to guard against changes to service provision that may have a positive impact on the headline waiting time indicator but are not in the interests of patients. Changes such as these should be avoided:

- reducing the average number of sessions that are given to patients who have a course of therapy (arbitrarily capping number of sessions)
- refocusing service provision on less severe cases, or those cases that are more likely to recover
- artificial treatment starts where patients have an early appointment but are then put on an 'internal' waiting list before a full course of treatment starts
- offering a limited choice of NICE-recommended therapies for depression.

8.1 Best practice

8.1.1 Making good use of stepped/stratified care

It is important for services to implement effective stepped/stratified care to optimise benefit for patients and maximise capacity. Session-by-session outcome measures, regular reviews and outcomes-focused supervision can support appropriate stepping decisions. Effective stepping ensures that the patient receives the right treatment in a timely way and avoids excessive doses of therapy that can impact on service capacity and waiting times. In order to ensure that patients get to the right treatment initially, it is important that the initial assessment leads to an accurate designation of the appropriate problem descriptor. When it is clear that patients should go to high-intensity therapy, services should avoid requiring them to receive a step two intervention first. Overall, this is a practice that consumes more therapist resources and therefore has a negative impact on waiting times, alongside patient experience.

Joint provision of low- and high-intensity therapy services is good practice as it makes it easier to ensure that patients transition smoothly and without undue delays between the two steps. Where this is not possible, local partnerships should ensure protocols are in place to monitor waiting times across the pathway when patients are stepped up or down. Systems

and providers should aspire to achieve the waiting times standard for all treatments and put local care pathway monitoring in place to ensure that all waiting times are visible and minimised. It is important to ensure the correct data capture of 'entering treatment' to guard against in-service pathway waits, including waiting times from first to second treatment appointment and between therapy types. Times of transition, between assessment and treatment, or between steps, may represent times of particular risk of harm to patients, including suicide, so processes should be developed to maintain contact and treatment momentum at these times.

8.1.2 Reducing missed appointments

Initiatives that aim to reduce missed appointment rates (also known as Did Not Attends/ DNAs) can play an important role in reducing overall waiting times.

The following have been linked to reductions in missed appointments:

- Ensuring telephone contact is made with patients to agree initial and rescheduled appointments, rather than sending appointments that have not been agreed.
- An online choose-and-book system for appointments.
- SMS text reminders of the date and time of an appointment.
- Robust local processes for managing non-attendance at appointments that are clear and communicated to patients entering the service at the point of referral, including therapy agreements that establish clear guidelines, rights, and responsibilities that both parties must adhere to during therapy sessions.
- Assurance that clinicians are following agreed non-attendance processes.
- Appropriate choice of treatment (where aligned to NICE guidance), mode of delivery, venue and clinician can all help to promote engagement and reduce missed appointments.
- Appointments offered flexibly to promote engagement and attendance.
- Local processes in place to quickly follow-up patients who do not attend an appointment and to actively encourage re-engagement, which includes a process that allows for re-assessment if the patient feels their needs are not being met.
- Robust processes for analysing data to look for any patterns in service usage, outcomes, pathways, and waits. This should also identify missed appointment patterns which may benefit from further investigation and action to reduce reoccurrence.

8.1.3 Offering a choice of delivery

NHS Talking Therapies services support patient choice when there are two interventions that are equally effective at a population level because research shows that at an individual level receiving one's preferred treatment tends to be associated with better outcomes.

Group work

For some clinical conditions and symptom severities, NICE recommends group work as well as one-to-one therapy (see Table 2). Not all patients are willing to join a group. However, if they find this an acceptable option, group treatment can be a way of reducing the average clinician time per course of treatment which can have a positive impact on waiting times. Groups need to be delivered in line with NICE guidance. Group CBT is a high-intensity therapy option which should be led by a trained high-intensity therapist, usually supported by another clinician. Guided self-help groups, which have a more restricted remit, may be led by appropriately trained PWPs. Guided self -help groups should be interactive and support

skill development and behaviour change. They may include psychoeducation, but pure didactic presentation does not constitute a complete intervention.

As with one-to-one therapy, group interventions should involve multiple sessions up to the numbers recommended by NICE for the relevant clinical condition. If patients find they are unable to attend a full course because of timing or other restrictions resulting from group administration, they should be offered alternative one-to-one therapy.

NICE guidance does **not** support the use of single session group interventions.

Digitally enabled therapy

Digitally enabled therapy is a fundamental part of the service model design. In this treatment approach, much of the learning that is required to help patients deal with emotional difficulties can be achieved by them working through materials on the internet with ongoing contact with an appropriately trained NHS Talking Therapies therapist (by telephone, secure messaging, video call, and so on) to provide encouragement, clarify misunderstandings and further enhance learning. There is evidence to show that some digitally enabled therapies can achieve comparable outcomes to face-to-face therapy, with less therapist time which could help reduce waiting times and/or increase accessibility. Digital treatment options do not suit everyone and must always be presented as part of a range of appropriate treatment options, including non-digital alternatives. Efforts should be made to maintain minimal waiting times across the range of interventions so as not to tempt those who do not wish to use digitally enabled therapy to select this option to avoid long waits.

NHS England's Digitally Enabled Therapy assessment criteria assess DET's suitability for use in NHS Talking Therapies services, and can be used to help commissioners select DETs appropriate for their needs. NICE have also published Early Value Assessments (EVAs) on Digitally Enabled Therapies for depression and anxiety disorders.

8.1.4 Capacity and demand modelling

Capacity and demand modelling is an invaluable tool for managing waiting times. It supports services to:

Set reasonable standards for attended clinical contact hours per week

Clinicians will appreciate clarity on this issue and service cohesion is likely to be enhanced if clinicians can see that clinical loads are fairly shared. Wellbeing and retention should be a key priority in services. Decision-making about clinical hours for both PWPs and HITs should also take into account:

- modes of delivery (phone, face-to-face, video platform, groups, and supporting digitally enabled therapies)
- appointment duration (for example, longer appointments for home visits or particular interventions)
- availability of fit-for-purpose technology (for example, headphones, laptops, IT)
- liaison with other healthcare professionals
- supervision, meetings, and other responsibilities (e.g., champion roles).

For high-intensity therapists it is generally considered that achieving 20 attended/delivered clinical hours per week is appropriate for a full-time, fully trained individual, with pro-rata reductions for part-time workers, trainees and those with supervision, management, or other responsibilities.

Working towards achieving 18–20 attended/delivered clinical hours per week is generally appropriate for a full-time, fully trained PWP, with pro-rata reductions for part-time workers, trainees and those with supervision, management, or other responsibilities.

More than 20 attended clinical contact hours is not recommended and may be detrimental to both wellbeing and clinical effectiveness. It is important that services achieve a balance between utilisation of clinical time and staff wellbeing.

What constitutes a clinical contact?

To job plan for attended/delivered clinical hours, the full range of clinical contact should be included: Assessment sessions, treatment sessions, direct contact with patients regarding any aspect of managing their care, and indirect contacts, for example with family members or professionals about a specific patient.

How to calculate session numbers

To calculate the number of sessions during a course of treatment, direct contact with a patient for assessment or delivery of therapy is included . This may be by video link, phone, in-person, or group. The calculation excludes:

- additional contacts that are provided as adjuncts to regular treatment sessions (such as emails and SMS texts).
- indirect contacts with other professionals or family members, or for administration time prior to or after the contact, e.g., scheduling or writing notes.
- travelling time to and from the contact.

How to calculate costs per patient contact

To calculate service costs per patient contact, all direct contacts with patients should be included, including assessment and treatment, responding to complaints, following up on non-attendance or other aspects of managing their care. Overall cost per service will always exceed the costs calculated using this method.

Maximise clinical contact time

Identifying and removing unnecessary or inefficient administrative processes that reduce the time that clinical staff have for seeing patients. This can include:

- processes to reduce DNAs so overbooking can be kept to a minimum
- processes to effectively manage clinical time lost to DNAs/ last-minute cancellations
- travel time
- availability and type of administrative support, e.g., appointment booking/ confirmation, waiting list management, diary management, and data entry of outcome measures.

In order to make best use of available clinical time, and to ensure equity between different clinicians within a service, formal job plans should be agreed for each type of worker within the service. Alignment with job plans should be regularly monitored and supported in supervision. Having such plans in place ensures efficient use of available clinical time whilst ensuring that workforce wellbeing remains at the forefront of service delivery.

See the FutureNHS platform for an example job plan template.

Session length

High-intensity sessions: These typically last 50-60 minutes but should be 90 minutes for SAD and PTSD. Longer sessions should also be scheduled in other disorders when out of office behavioural experiments are planned, also when patients require interpreters.

PWP sessions: To deliver all the core features of PWP assessment in the past, a minimum of 45 minutes was required. The current update of the manual has expanded the activities expected for the initial assessment session to include a new safety assessment and formulation procedure and time spent on socialising patients for treatment and generating hope. Adequately covering these in the assessment session may require more than 45 minutes, though this extension could be partially offset by advance data collection using digital front doors or online forms.
To deliver all the core features of a PWP treatment session a minimum of 30-35 minutes is required.
Treatment sessions may be shorter where there is a specific Manual-recognised protocol that supports this (e.g. some digitally enabled therapies).
Assessment and treatment sessions will need to be longer when interpreters are used or where there are other specific needs.

Develop a service model to improve efficiency and maximise capacity

Services should promote lean referral systems: over-complicated referral systems and pathways create more variation and require more resources.

NHS Talking Therapies providers are encouraged to undertake detailed modelling that considers several factors. See the Mental Health System Improvement Network page on the FutureNHS platform for more information.

There are two elements to effective modelling:

1. Ensure that the necessary capacity to meet demand for each type of treatment. Capacity calculations need to:

    - Be based on realistic expectations of productivity and consider expected loss of capacity due to annual leave, sickness and staff training events.
    - Consider missed appointments and short-notice cancellations, because rescheduling after a missed appointment requires an extra session of therapist time.
    - Include the capacity needed to deliver a full course of treatment, not just the first and second appointments.
    - Take account of all clinical contacts including those to support patient engagement such as following up missed appointments or complaints, and messaging patients between sessions (common with digitally enabled therapies).

2. Identify if there are too many patients waiting for each step or therapy modality to meet the agreed waiting standard:

    - A waiting list is defined as all patients waiting for an intervention, irrespective of whether they have been given the appointment date and/or been allocated to a clinician.
    - There is a direct relationship between the number of patients waiting in each stage of a pathway and how long those patients will wait. As a rule of thumb, a 4-week

wait will be delivered if there are no more than 2–3 weeks of new patients waiting for their first session. A 6-week waiting standard can be achieved with no more than 4–5 weeks of new patients waiting.

- Services should not attempt to reduce wait times for an initial assessment by introducing or extending waits later in the pathway. If it is agreed that a patient should have a course of treatment, sessions should start promptly after the assessment. If a patient starts with a low-intensity treatment and has to be stepped up to high-intensity this should also happen promptly. When there are long waits between the last low-intensity treatment and the first appointment for high-intensity treatment outcomes are worse, partly because patients tend to drop out of the service.
- If there are more patients waiting than the rule of thumb maximum, the excess number is termed the 'backlog'. It is important that there is clarity about who is responsible for clearing backlogs, as well as whether this will be achieved within existing resources, by redesign, by increased efficiencies or if it requires additional (one-off) funding.
- The scale of patients waiting is often shown as 'clearance time' (in weeks). Clearance time is the number of weeks it would take to clear a waiting list if no further new patients arrived. Clearance times give an indication of the size of the waiting list irrespective of the size of the service or actual numbers on the waiting list, and are a useful measure for monitoring variation between, or progress within, a service or waiting list.

Commissioners should ensure that the service capacity required to deliver the identified level of activity is funded recurrently, with performance monitoring and contract levers in place to ensure that the agreed volumes of activity are being delivered in line with the high-quality expected.

A good understanding of capacity and demand modelling enables providers to be confident in their estimates of how many staff they require to deliver the expected demand and ensure that there is senior agreement that those staffing levels are in budget and in post.

Capacity-demand modelling should be based on achievement of all expected NHS Talking Therapies metrics nationally. These national targets recognise that there will be local variation. It is important that high-performing services continue to be high-performing, leading the way for others. High-performing services should not reduce their performance to the national mean. High-performing services benchmarking to the mean will lead to national performance targets not being met.

9 Principles of good waiting list management

Sustainable delivery

Systems and providers will need to have a good understanding of the sustainability of their NHS Talking Therapies services. That is, the number of referrals, the number of first appointments and the number of subsequent treatment sessions required to achieve the key metrics.

Achieving the NHS Talking Therapies waiting standards whilst maintaining a good patient experience

Written pathways with senior clinical sign-off should be in place with agreed waiting standards for assessment, first treatment and all subsequent treatments in line with national NHS Talking Therapies referral to treatment standards.

As far as possible, variation in waiting standards for first treatments should be minimised so that all patients can be 'seen in turn'.

- Providers should ensure that there are plans in place to address unequal waits for particular locations, localities and/or clinicians, particular therapy types and for modes of delivery.
- Providers should ensure that the number of different care pathways are minimised because they lead to inefficiencies.

Systems and providers should ensure that there are no avoidable delays after initial appointments and that all waits during a course of treatment are clinically appropriate. This applies to waits between first and second appointments, but also to waits between later appointments and for the start of new treatments within the stepped/stratified care system.

Patient tracking list (PTL) management

Most NHS Talking Therapies information systems will provide a list of patients on a waiting list for a particular activity. While this can be used for simple booking, it is rarely adequate for proper oversight and management of a team or service.

PTL-style (defined as Patient Tracking List, Patient Target List or Priority Tracking List) waiting list reports are more helpful for visualising where in a system patients are waiting, to identify in which team, modality or area any waiting list pinch-points might be and to give adequate organisational assurance that waiting times standards are being met.

The exact format of the PTL is for local decision. See the Mental Health System Improvement Network workspace on the FutureNHS platform for information about PTLs, including example formats and best practice case studies.

A key rule for effective waiting list management is to set up a system in which most patients are automatically allocated appointments based on their order in a list. Management intervention should be by exception. The visual overview provided by a PTL enables managers to focus on areas of concern.

The key features of a PTL are:

- **The setting of a target (or breach) date**
  - For first appointments, this is straightforward because there is a mandatory 6-week waiting time standard. Each patient should be offered a date within 6 weeks. Some patients will not be able to take up the offer for good reasons (holidays and so on). This has been considered by setting the service target of at least 75% seen within 6 weeks.
  - For subsequent treatment appointments, internal standards should be agreed that are clinically appropriate. For example, if a therapy is normally based on weekly appointments, gaps between sessions should rarely exceed that amount. Similarly, transitions between one step and another should be timely.

- **Breakdown of waits**
  - The waiting list can be split by therapy modality and step, by locality, by therapist or other useful divisions. Patients who have been waiting too long can be identified, with target activities agreed.
- **Regular 'PTL meetings'**
  - It is good practice to review PTLs on a regular (weekly or fortnightly) basis and agree team action.
- **Senior oversight and governance**
  - PTL meetings should be chaired by a senior manager responsible for delivery of performance in the service who has sufficient authority to ensure that agreed actions are followed up.
  - A clear escalation policy should be in place for situations in which it is not possible to offer appointments in line with the agreed (national and service specific) wait standards.

Clinical safety and effective management of cases

Services should not have inactive cases that remain open despite not having a clinical appointment or review for extended periods of time. This poses significant risks with regards to patient safety and also impacts on the accuracy of the data captured regarding the effectiveness of NHS Talking Therapies both locally and nationally.

Clinically, it is recommended that patients who have completed a course of talking therapy go no more than two to three months following the completion of this before a review and/or discharge. This is to ensure that clinical gains are maintained.

NHS Talking Therapies services should not have cases showing as open with no activity for longer than this three-month period. Where this is the case, it suggests that caseload management, patient tracking lists and pathway oversight are not effectively in place in a way that assures clinical safety.

Services should ensure that any cases with no activity for more than three months are reviewed as a priority and that the below are in place to ensure that patients receive the best service possible in line with NICE guidance:

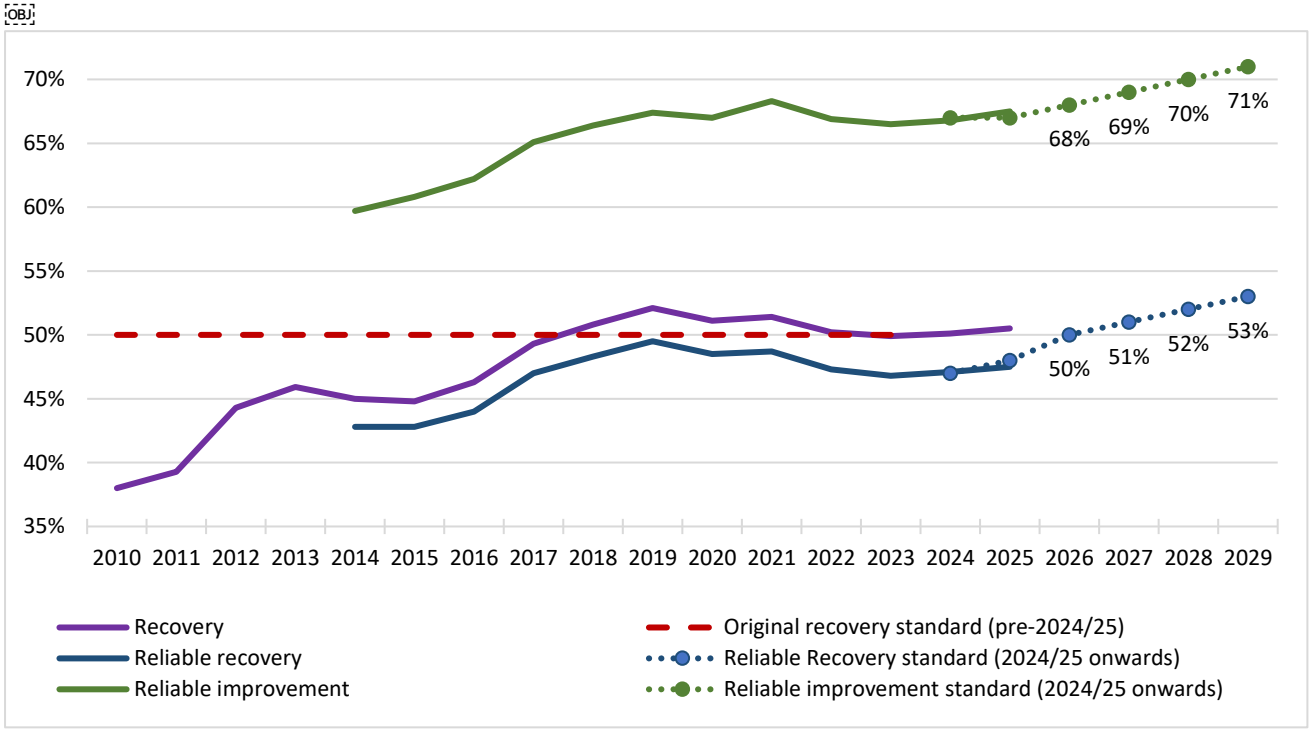
- Case management in line with NHS Talking Therapies Manual recommendations.
- Minimum fortnightly review of Patient Tracking Lists (PTLs).
- Clear DNA/ cancellation policies and adherence to these.
- Clear follow up/review policies in place for those on waiting lists who may not be seen for a clinical appointment within the 2–3-month time frame.

The guidance above considers all open cases that have had no 'clinical' contact for more than 90 days. Any contacts that are not clinical e.g., contacts where outcome measures are taken, and some form of treatment takes place do not meet this criterion. The data shared with regions shows all 'open' cases that have not had a 'clinical' contact in over 90 days.

9 Getting better results: improving recovery, reliable recovery, & reliable improvement

From the beginning, NHS Talking Therapies set itself an ambitious target in terms of clinical outcomes. Taking into account the outcomes that can be achieved with NICE-recommended treatments in clinical trials and allowing for some attenuation in routine practice, it was suggested that it should be possible for around one in two patients to achieve recovery and two thirds to show worthwhile improvement. Since 2017 NHS Talking Therapies services have consistently achieved these ambitious targets (Figure 7). This is a great achievement. However, there are two reasons for thinking that further improvement in outcomes is possible. First, a substantial number of services consistently achieve recovery rates above 50%. Second, multiple modifiable factors that are associated with good outcomes have been identified. In recognition of these two observations, the government has provided additional funding to enable services to treat more people and also improve outcomes in the period 2024/05 to 2028/09. The outcome targets are shown by dotted lines in Figure 7. Services are encouraged to assess themselves against the best practice indicators and work to improve in any relevant areas.

Figure 7: Clinical outcomes



Outcome standards to be achieved by the end (March) of each year

This chapter summarizes knowledge on how to improve service outcomes.

9.1 Best practice

Valuable lessons about how to improve clinical outcomes have been learned from published research studies and from NHS England's internal analyses, including those commissioned from University College London.

9.1.1 Importance of providing NICE-recommended treatment

NHS Talking Therapies services are expected to provide patients with NICE-recommended treatment. However, a minority of patients receive treatments that are not in line with NICE guidance. This creates a natural experiment. Comparisons between the outcomes of patients whose treatment follows NICE guidance and those of patients whose treatment deviates from guidance generally indicate that outcomes are better when NICE recommendations are followed.

An early study used patient-level data from the 32 services established in the first year of the NHS Talking Therapies programme to compare the outcomes achieved with CBT and counselling.[19] NICE recommends both for the treatment of depression (see Table 2). Consistent with this recommendation, there was no difference in the recovery rates associated with CBT and counselling among patients with a depression problem descriptor. In contrast to the recommendation for depression, NICE does not recommend counselling for the treatment of anxiety disorders. Consistent with this position, CBT was associated with a higher recovery rate than counselling among patients with an anxiety disorder problem descriptor.

A further natural experiment emerged in the data for low-intensity interventions. For the treatment of depression, NICE recommends guided self-help but not 'pure' (non-guided) self-help. However, a significant minority of patients received pure self-help. Consistent with NICE, guided self-help was associated with a higher recovery rate than pure self-help among patients with a depression problem descriptor.

NICE does not recommend stepped care for PTSD or Social Anxiety Disorder. Patients should be immediately allocated to the relevant high-intensity treatment. However, a minority of patients are given low-intensity treatment. A recent analysis [31] found that outcomes for PTSD and Social Anxiety Disorder with low-intensity treatment are very poor (25% to 35%), while those associated with high-intensity treatment are in line with the recovery standard.

9.1.2 Offering an adequate dose of therapy and minimizing drop-out

Adequate dose. Services that give a higher *average* number of treatment sessions achieve better outcomes [21.] Looking at all patients treated in a service the optimal *average* number of sessions appears to be nine to ten [21]. However, recent analyses suggest that problem descriptors and severities may vary in the *average* number of sessions that are required to achieve reliable recovery (Table 10). Of course, some patients will recover with less than the *average* number of sessions and some will require considerably more sessions.

Table 10: Average number of contacts to achieve reliable recovery by problem descriptor and initial severity

	Problem Descriptor	Severity	Average number of contacts to recover
F32 or F33	Depression	Mild	7.0
		Moderate	8.0
		Severe	9.0
F411	Generalised Anxiety	Mild	7.0
		Moderate	7.0
		Severe	8.0
83482000	Body Dysmorphic Disorder	Below Median	12.3
		Above Median	14.1
F431	Post-traumatic Stress	Below Median	11.3
		Above Median	12.3
F42	Obsessive Compulsive	Below Median	12.1
		Above Median	13.0
F401	Social Anxiety Disorder (Social Phobias)	Below Median	12.0
		Above Median	11.2
F452	Hypochondrial Disorder (Health Anxiety)	Below Median	9.3
		Above Median	11.0
F402	Specific Phobias	Below Median	9.0
		Above Median	10.4
F412	Mixed Anxiety and Depression	Below Median	6.2
		Above Median	8.0
F400	Agoraphobia	Below Median	8.0
		Above Median	8.4
F410 -	Panic Disorder	Below Median	9.1
		Above Median	8.3

NB. For panic disorder and social anxiety the data shows that it takes more sessions to reliably recover when severity is below median. This would be a function of combining LI and HI therapy and the step up mid treatment where there would be a step up mid treatment. Those with higher severity require fewer appointments as would start treatment at high-intensity.

In general, patients should be offered **up to** the NICE-recommended number of sessions for the relevant clinical condition. For high-intensity work this would generally be in the range of 12 to 20 sessions, depending on the problem descriptor and severity/complexity. In some of the most complex cases more sessions are required. It is good practice to offer an initial number of sessions followed by a review to decide whether treatment should continue, whether there should be a change of approach (such as stepping up), or whether a reformulation would be appropriate. Treatment should be continued if the patient has not

recovered and there is reason to believe that further improvement can be achieved by continuation of the current treatment or by switching to another treatment.

Drop-outs. Some patients who are judged appropriate for treatment in NHS Talking Therapies services currently receive a very small number of sessions before discharge. For these people, recovery rates are poor (25% with 2 sessions, 35% with 3 sessions). Recent analyses [31] show services vary considerably in the proportion of patients who receive just 2-3 sessions (range 11% to 40%) and this variability is strongly related to outcome (r= -0.45). Services with the lowest number of people having only 2-3 sessions have reliable recovery rates 7 percentage points higher than those with the largest proportion of such patients. Inspection of discharge codes indicates that many individuals who had only 2-3 sessions dropped out early (discharge code: “termination of treatment earlier than care professional planned”) suggesting an engagement problem. Services should strive to ensure patients remain engaged throughout the planned course of treatment, so they receive an adequate dose and are then discharged by “mutual agreement (see Section 9.1.8).The reliable recovery rate for all patients discharged by mutual agreement exceeds 65%, compared to less than 20% for those who terminate early.

9.1.3 Missed appointments

Services with higher rates of missed appointments (DNAs) have worse clinical outcomes and there is evidence that when services reduce DNA rates, outcomes improve [21]. Sending SMS reminders about appointments can be helpful, as can flexibility about scheduling the time of appointments or their modality (in person vs remote). There should be no policy of discharging patients after two DNAs without taking into account personal circumstances and co-occurring needs (for example, ADHD, difficult home circumstances, shift workers etc.)

9.1.4 Waiting times

The national KPI covers the wait from referral to assessment (session 1). Most services meet the KPI. However, research shows that the wait from assessment (session 1) to the effective start of treatment (session 2) is a strong determinant of outcomes. Services that have shorter wait between initial assessment and the start of treatment achieve better outcomes [21, 31]. This may be because patients lose enthusiasm for engaging in therapy if they have to wait too long after making the decision to come forward for treatment, or they may deteriorate further.

Many services have configured their workforce so patients can start low-intensity treatment promptly after an assessment (average 7 days in 2024/25). In the same year average waits to start high-intensity treatment were much higher (over 70 days from assessment to high-intensity as a first intervention or between low-intensity and high-intensity treatment if patients are stepped up). Again, services vary considerably (range 40 to more than 200 days) and this variability predicts outcomes. Services with longer waits have poorer outcomes. Greater expansion of the high-intensity workforce will be necessary to overcome the high-intensity waits problem.

9.1.5 Problem descriptor completeness

The NICE-recommended approach to treatment varies according to the problem descriptor as specified by ICD. For some clinical conditions (such as depression) several types of therapy are recommended. For others (such as the anxiety disorders) only one type (CBT) is recommended (or in the case of PTSD, trauma-focused CBT or EMDR), but the protocols used can be radically different depending on the problem descriptor For example, video feedback is strongly recommended as part of CBT for social anxiety disorder but plays no role in the treatment of PTSD, where there is a much stronger emphasis on memory work.

For this reason, assessors in NHS Talking Therapies services are encouraged to work with patients to describe accurately the problems that they would like their treatment to focus on and to give these the appropriate problem descriptor. Services with higher rates of accurate problem descriptor identification achieve better outcomes [21], presumably because they are more able to ensure patients get the right treatment. In 2025 some services identified a problem descriptor for every patient who had a course of treatment while other services failed to identify problem descriptors in over a third of the treated patients.

9.1.6 The importance of using the correct outcome measures

Under-use of the relevant ADSMs or MUS/ PPSx measures can have a negative impact on patient outcomes, including the following factors:

- Patients may not benefit from therapy as much because clinicians are missing critical information to guide therapy (such as, what situations are avoided, whether intrusive memories are a problem, and so on).
- Patients may be discharged too early. For example, in a clinical trial of psychological treatment for social anxiety disorder most patients achieved recovery on the GAD-7 and PHQ-9 by the midpoint in therapy but only showed marked reductions in disability and a high recovery rate on the social anxiety ADSM (SPIN) and the PHQ-9 when the full course of treatment was completed. Clinicians who were only guided by the GAD-7 and PHQ-9 would be tempted to discharge patients before they have fully benefited but would be unaware that they are doing so, risking patient relapse.
- Serious clinical problems may be missed. Patients who show marked avoidance (for example, agoraphobia) may not be classified as in caseness on the GAD-7/ PHQ-9 and so would not count towards recovery numbers in a service, even though they may initially be severely disabled (for example, housebound) and subsequently overcome their disability.

ADSMs and MUS measures need to be used routinely to plan treatment and record outcomes, this can be done by:

- Ensuring IT systems flag that a particular ADSM or MUS measure is recommended if the relevant problem descriptor is present.
- Training staff on the value of ADSMs and MUS measures.
- Using local and national reports to monitor the percentage of cases that had a relevant anxiety disorder as their problem descriptor, and paired scores on the appropriate ADSM following completed treatment.
- Ensuring internet-based programmes automatically collect an ADSM or MUS measure, if one is relevant.
- Producing a ‘what to expect from your treatment’ document that is given to all patients when they start treatment in an NHS Talking Therapies service. This should include clear information that they can expect an assessment that collaboratively identifies the main problem(s), explains the NICE-recommended treatments for each problem and what they involve, and gives a list of the measures they should be given based on their clinical condition.

Recent analyses [31] of the NHS TT data set have confirmed the crucial importance of ADSMs. When clinicians use the relevant ADSM to guide treatment outcomes are much better. The analyses controlled for various possible confounding factors. If we measure recovery the same way (so with PHQ & GAD) the rates for PTSD were 53% with ADSM guiding treatment vs 32% without the ADSM. For social anxiety disorder the difference was 63% with ADSM and 44% without. For Obsessive-Compulsive Disorder the difference was 60% with ADSM and 45% without. For panic disorder the difference was 63% with ADSM

and 51% without. Part of the explanation appears to be that clinicians provide more sessions when using ADSMs (for PTSD 12 sessions on average when using ADSM compared to 8 sessions on average when not using ADSMs). However, even when one controls for number of sessions, using ADSMs is associated with better outcomes. This means that every hour of therapy is more effective when guided by ADSMs, perhaps because they help therapists stay focused on the primary problems that patients have identified.

9.1.7 Automated feedback to therapists indicating that patient progress is off track.

Delgadillo and colleagues (2018) [32] used NHS TT session by session outcome data to develop an algorithm to estimate the expected improvement in PHQ-9 and GAD-7 for individual patients as they progress though treatment and to indicate when a patient is doing less well than expected ("off-track"). In a randomized controlled trial, they showed that feeding back to clinicians that a patient was off-track improved the outcomes of that subset of patients. As the feedback algorithm is based on PHQ-9 and GAD-7 it is relevant when the problem descriptor is depression or generalized anxiety disorder, but not for conditions requiring an ADSM.

9.1.8 Improving engagement with therapy

The dramatic difference in outcomes between patients whose treatment finished by mutual agreement between patient and therapist (reliable recovery > 65%) and those dropped out, (reliable recovery < 20%) highlights the importance of therapeutic engagement. This should start in the initial NHS TT assessment appointment. While the main aim of the initial session is to identify the problem(s) that require treatment, the success of the subsequent treatment will also depend on the extent to which the initial and early sessions

- form a positive therapeutic alliance, inspire hope, motivation for change and belief in the intervention. Numerous research studies have shown that patients' early ratings of treatment credibility are a strong predictor of outcome.
- clearly communicate the evidence base, indicating the number of sessions the evidence tells us is required to get better (using an analogy to the use of antibiotics to illustrate the importance of the right 'dose' of therapy to feel better).
- clarify what treatment involves. The term NHS Talking Therapies is popular with the public but can lead patients to think that therapy just involves talking. They may not expect the multiple practical assignments involving behaviour change that are part of cognitive-behaviour therapy and low-intensity interventions, or other homework assignments common to many modalities of treatment.
- include agreement between therapist and patient to check in on progress regularly, and explicit invitations to the patient to provide regular feedback about what is helping/ not helping.
- ensure scheduling of sessions takes into account patients' circumstances (work & family commitments, planned holidays, etc)

To ensure there is time to promote therapeutic engagement in the first sessions, clinicians may find it helpful to have basic information about a patient collected in advance by an online form or a digital front door.

Once a patient has started treatment, it is important to maintain engagement. There are many relevant procedures

- promote a good therapeutic alliance and resolve any difficulties as they arise in the alliance.
- confirm the problem descriptor is accurate

- focus on patients' goals
- provide encouragement
- identify and deal with blocks to progress. For example, if a homework assignment has not been done, don't just set it again. First, find out what was the blocking the person from doing the assignment and overcome the block in the therapy session. For difficult behavioural assignments this may involve doing the assignment with the patient in the session, as well as breaking it down into more manageable stages.
- plan future sessions in line with the initial goals for treatment.

9.1.9 A focus on providing therapy

Services which have a high proportion of referrals that receive a course of therapy (2 or more sessions) have better overall clinical outcomes [21]. This is probably because the services and their staff are strongly focused on delivering treatment, rather than a wider range of activities such as general signposting, advice, and one session groups.

9.1.10 Making the most of stepped/stratified care

Services should offer a stepped/stratified care model that provides patients with the appropriate level of care for their needs. Services with higher step-up rates among patients who have not recovered with low-intensity interventions have higher overall recovery rates [21]. Stepping decisions should be supported by outcomes-focused supervision and local processes to ensure effective communication with patients.

9.1.11 Social deprivation

In addition to the organisational variables mentioned, analyses of the national data show that the level of social deprivation is a predictor of outcome. Services in more socially deprived areas tend to have poorer outcomes. However, even in the most deprived areas, there are NHS Talking Therapies services that meet the key performance metrics. This is perhaps because research shows that the effect of social deprivation is reduced when quality standards, such as those mentioned above, are taken into account [21]. This means that if a person lives in a socially deprived area, it is particularly important that they have access to a high-quality NHS Talking Therapies service.

9.1.12 Provide a choice within NICE-recommended treatments

When NICE recommends a range of therapies for a particular clinical condition, services should be commissioned so that patients can be offered a choice between the recommended treatments. Research shows that treatments that are considered to be more credible by patients are more likely to be effective. This suggests that the availability of choice is likely to improve clinical outcomes.

Patients should also be offered meaningful choices about where, when, how, and by whom therapy should be delivered. Providing such choice is likely to enhance engagement and, consequently, improve outcomes.

9.1.13 Importance of clinical leadership

The quality of clinical leadership in a service is critically important. In better performing services, the clinical leaders have a strong focus on patients' clinical outcomes. They help to create an environment of innovation in which staff are curious about the service's outcome data primarily because it indicates how to further improve their clinical work.

Staff should receive personal feedback on the outcomes that they achieve with their patients, benchmarked against the service's average. For such benchmarking to be effective, it is essential that it occurs in a supportive environment.

The NHS Talking Therapies programme has benefited from having clear clinical targets. However, targets are a double-edged sword and transformational leadership can be challenging in the context of difficult financial situations, staff turnover and performance demands. Under poor leadership, targets can appear burdensome and oppressive. Under good leadership they can facilitate improved patient outcomes and result in staff feeling supported and appreciated, at the same time as creating an innovative environment in which the information captured by NHS Talking Therapies data reports is seen as a source of good ideas that everyone can participate in, rather than a mechanism for harsh performance management.

NHS Leadership Academy provides a variety of resources to support staff training and development.

9.1.14 Data-driven reflective practice

Some NHS Talking Therapies services have used the Plan, Do, Study, Act methodology[22] to improve the outcomes they achieve. For a short period of time (say 1 month) the service reviews the notes and other available information on all patients who did not achieve recovery by the end of treatment. Careful study of the information is then used to think about changes to service provision that might have helped the patients to gain further benefit. These changes are then implemented, and their effect observed. Pimm (2016) reported that this method enabled improvement from an average recovery percentage in the mid-40s to one in the mid-60s[23].

Developing detailed performance reports that allow outcomes to be monitored by clinician, team, modality, and problem descriptor is an essential part of reflective practice. Outcomes-focused supervision and live supervision (including session recordings and the use of profession-specific rating tools) can support continual learning. Creating a resilient and experienced workforce that together can help manage a full range of patient problems, including more severe and complex presentations, needs careful consideration. Leaders should support staff to attend multiple CPD events to ensure clinicians adhere to the evidence base and avoid therapist drift. Ongoing planned CPD is essential to ensure staff are appropriately trained and re-trained to treat the problems appropriate to NHS Talking Therapies services.

It is important to note that patients who do not achieve recovery can still achieve worthwhile benefit. It is expected that two thirds of patients treated in NHS Talking Therapies services should reliably improve and lead more fulfilled lives by implementing the tools learned in therapy. It is important to analyse local data to understand patterns of improvement and deterioration, to ensure delivery of therapy that is safe and benefits the maximum number of patients.

9.1.15 Follow-up after treatment

Common mental health problems can be recurrent and chronic. Psychological therapies have the potential to reduce recurrence by teaching patients' skills that they can use in the future.

Research studies have shown that high-intensity therapies that include relapse prevention procedures in their basic protocol can lead to more sustained gains and reduce relapse when compared with medications[24]. Follow-up of patients also shows that the gains achieved in therapy are largely maintained at follow-up.[17] However, services should not assume that patients will stay well after treatment and instead should put in place a comprehensive set of procedures that are likely to reduce relapse and improve long-term outcomes.

These procedures might include:

- **Focusing on ensuring that patients learn skills for overcoming emotional problems, in addition to meeting symptom recovery criteria**. Some patients, particularly those with less severe depression, could recover during treatment without learning any skills because they were going to recover in that period of time anyway (natural recovery). Such patients will be at increased risk of relapse unless their therapist or PWP ensures that key skills have been learned.
- **Developing a relapse prevention plan with patients before they are discharged**. Typically relapse prevention protocols involve writing out the key learning points from therapy and looking to the future to anticipate any likely stressors or setbacks. A simple plan of how to deal with the stressors or setbacks is then developed and written down. It will involve returning to some of the strategies that worked in therapy as well as linking up with helpful resources, including contacting their clinician for a booster session, if appropriate.
- **Scheduling one or more post-treatment follow-up sessions**. Follow-up sessions 3 to 6 months after the end of treatment are an excellent way of detecting early signs of relapse that can be dealt with by a brief therapy booster before they become more problematic.
- **Co-ordinating with GPs if a patient is considering stopping medication during follow-up.** Some patients experience a re-emergence of symptoms following discontinuation of medication. This is more likely if medication is withdrawn quickly. Liaison with GPs to agree withdrawal schedules and to monitor patients during withdrawal is therefore advised.

Digital tools may facilitate follow-up. For example, the Paddle app prompts patients to fill in their key outcome measures at regular intervals during the follow-up year, gives the patient easy access to their relapse prevention plan, and provides a re-referral route if relapse occurs

9.1.16 Other interventions

Pharmacological interventions. There is a good evidence base on the effectiveness of pharmacological interventions, alone or in combination with psychological therapies, for the treatment of common mental health problems. When pharmacological interventions are prescribed, it is important that a close partnership is established with the GP, patient, and NHS Talking Therapies clinician. NICE guidance recommends considering the concurrent use of medication in more severe depression. However, in less severe depression, routinely offering antidepressants as a first line treatment is not recommended unless that is the patient's preference.

9.1.17 Characteristics of better and worse performing NHS Talking Therapies services

Table 11: Summary of characteristics of better and worse performing NHS Talking Therapies services

Better performing services	Worse performing services
Leadership that is focused on reliable recovery and reliable improvement data in an inquisitive and staff supportive manner	Patients are offered a fixed, low number of treatment sessions. Many patients drop-out early.
Staff get personal feedback benchmarked against the service average or other clinicians	Patients are discharged before they recover despite showing consistent improvement during treatment
Staff wellbeing programmes are in place	Staff wellbeing is not an explicit focus
Most patients receive a course of treatment (mean 62%)	Clinicians are unaware of, or not attending to, clinical cut-offs
Problem descriptors are identified for all patients who receive a course of treatment	A sizeable proportion of patients are treated without identification and recording of their main problem descriptor.
Regular administration of ADSMs or MUS measures is used to track progress during treatment, when appropriate	Failure to use ADSMs or MUS measures as necessary
Appropriate outcomes-focused supervision, CPD and support of staff wellbeing	Supervision is vague and infrequent. No staff well-being programme. Few opportunities for CPD.
Effective commissioning of adequately staffed services with clear pathways and avoidance of perverse incentives	'Mixed anxiety and depression' is incorrectly used as the problem descriptor when a patient meets criteria for **both** depression and one or more anxiety disorders. Consequently, the service is unable to determine if the correct NICE-recommended treatment has been chosen
Capacity and demand modelling following good principles of waiting list management, including PTLs	Non-guided self-help is given despite not being a NICE-recommended intervention
Short waiting times to the start of treatment without appreciable in-service pathway waits later in the course of treatment	A low percentage of patients receive a course of treatment with high numbers of 'one-off' appointments
Patients are offered up to the NICE-recommended number of treatment sessions, unless they recover earlier	Higher waiting times
Employment advisers embedded alongside clinicians providing effective	Little or no focus on employment

Better performing services	Worse performing services
joint working to support clients with employment issues.	
Clear co-production approach, where patients co-produce service change, evaluation and improvement with clinicians. Expertise by experience is valued.	Patients are not embedded into decision-making processes and do not co-produce service change, evaluation and improvement with clinicians.

10 Getting better results: improving equity of access and outcomes for all

10.1 Equality-focused services: understanding the local population

At the heart of the NHS constitution is equality and fairness – everyone has an equal right to access and benefit from NHS services. Depression or anxiety disorders can affect anyone, so demand for evidence-based therapies remains high across all communities.

Systems and providers need to understand the prevalence of depression and anxiety disorders within their local population, to extend the reach of their services more effectively. Some areas have a higher prevalence of depression or anxiety disorders. Others may have proportionately lower levels of identification rates, despite high need.

Systems should be explicit in their plans for how they will fulfil their duties under the Mental Health Act 1983 (amended 2007). To enable commissioners to meet these duties, equity of access and outcomes should be monitored and compared with prevalence of different groups within the local population. Services should be inclusive and actively promote equality, with consideration given to protected characteristics as defined by the Equality Act 2010, and their duties to reduce health inequalities as set out in the Health and Social Care Act 2012. Services should also operate in line with the Accessible Information Standard, which is a mandatory standard for all NHS services and is helpful to ensure that communication support needs (e.g. due to sensory loss, disability) are assessed and recorded at the point of referral to the service and then steps taken to meet these needs.

Service design and communications should be appropriate and accessible to meet the needs of diverse communities (see Guidance for Commissioners on Equality and Health Inequalities Legal Duties). Services should also review and publish outcome information by protected characteristics in a way that enables the team to progress towards eliminating discrimination, advancing equality of opportunity and fostering good relations between different groups. Publication of this data is also important to allow public scrutiny of progress. Systems should work to incentivise improvement in equity of access and outcomes, to both support and hold providers to account for meeting the needs of the local population.

Systems and service leads should inspect their local data to identify under-represented groups in their services. National data indicate that the following groups tend to be under-represented in NHS Talking Therapies for anxiety and depression services:

- Disabled people, including people with hearing impairments
- Autistic people
- Lesbian, gay, and bisexual people
- Transgender people
- Men
- Older people
- People from black and minority ethnic communities
- People for whom English is not their first language
- People with caring commitments
- People from deprived communities, including those who are on low incomes, unemployed or homeless
- People with learning disabilities[25]
- People in prison or in contact with the criminal justice system

- Refugees and asylum seekers
- Serving and ex-serving armed forces personnel
- People with specific anxiety disorders such as social anxiety, specific phobias, obsessive-compulsive disorder, and PTSD
- People with long-term physical health conditions
- People with addictions, including gambling and substance misuse.

Please see Section 10.3 for relevant Positive Practice Guides.

Some NHS Talking Therapies services are commissioned to provide treatment for under 18s. Anyone working with a child or young person should:

- Be trained to work with under 18s
- Understand their developmental needs and the differences in presentation between children, young people and adults
- Be aware of relevant legislation and safeguarding
- Use outcome measures validated for this age group.

10.2 Best practice

10.2.1 Developing local care pathways

Local care pathways should be developed in consultation with patient groups and community leaders. Collaboration is critical to enabling access to services for a range of under-represented groups. Working in partnership with patients is paramount to understand and overcome barriers that might hinder the effective shaping of local pathways. Closer working with the voluntary, community and faith sectors will improve access for diverse community groups who may find it more difficult to access services.

10.2.2 Workforce, education and training

Systems and providers should consider:

- Developing services that have bilingual clinicians who speak the languages representative of the local population, including clinicians who are fluent in British Sign Language for deaf people, or commissioning independent translation services.
- Ongoing CPD to build capability and competence in the workforce, including cultural competence.
- Ensuring an appropriate skill mix and workforce that is representative of the local population to ensure patients have a choice of clinician, for example gender or cultural background.
- Ensuring that all staff are aware of the positive practice guides and are implementing the best practice recommended within these.
- Ensuring that all staff have access to the eLearning courses that accompany the positive practice guides and long-term physical health conditions top-up training.
- Implementing the audit tool in the BAME Service User Positive Practice guide.
- Ensuring that all staff have undertaken the required mandatory and statutory training for their role, including the mandatory Oliver McGowan training. All NHS Talking Therapies staff should complete Tier 1 of the Oliver McGowan training. All NHS Talking Therapies clinical staff should complete Tier 2.

10.2.3 Improving access and modifying treatments for specific populations

Access for specific populations can be improved by considering the following:

- Choice of mode of delivery, venue, and gender and cultural background of the clinician can enable access to services. In line with meeting the needs of the local population, commissioners should ensure that providers have the right level of funding to undertake home visits for both assessment and treatment where appropriate.
- Self-referral routes, as patients from some sectors of the community are less likely to visit their GP and be identified as having depression or anxiety disorders.[26]
- Promotion is critical to enhancing self-referral. Adapting promotional materials and engaging with the wider system to promote the service and improve accessibility.
- Prompt and clear routes into the service with no over-complicated referral processes or opt-in systems will support engagement.

Treatments can be modified in the following ways to enhance equity of access and outcomes:

- Adapting session length and number where appropriate to accommodate pacing and/or use of interpreters.
- Adapting materials to be appropriate to different groups. This includes written communication and visually based resources available for patients who do not speak English as their first language and for patients with learning disabilities. A range of translated Step 2 materials are available on the FutureNHS platform.
- Use of technology can increase accessibility.
- Commissioners and providers should ensure that patients are given a choice in how evidence-based therapy is delivered.

10.2.4 Continuity of NHS Talking Therapies treatment when moving to a new area

Patients may move out of area whilst waiting for, or engaging in, NHS Talking Therapies treatment. It is important that, when this occurs, the patient is given the choice to continue their current episode of treatment with the existing service irrespective of their new geographical location. This is made more possible with greater use of remote delivery, ensures continuity of care and maximises sustained recovery.

Patients should not be discharged during a course of treatment purely based on changes in geographical location as treatment plans should always be driven by patient choice.

The NHS Choice Framework and Service Condition 6.8 within the NHS Standard Contract oblige providers to honour patient choice. This guidance should be referred to in any discussions regarding the treatment of patients outside any given ICB footprint.

This is a particularly important consideration for patients with multiple or unstable addresses including students, individuals in emergency accommodation and all inclusion health groups (e.g., asylum seekers, refugees, travellers). Students should be able to access NHS Talking Therapies treatment at either their term time or vacation address and continue with the same treatment when in the other location.

Where a patient is receiving NHS Talking Therapies treatment in a geographical location outside their GP's catchment area, concerns regarding risk that may require secondary care

intervention should be managed by the clinician and patient via the NHS Urgent Mental Health Helplines.
The following factors should be considered to maintain continuity of care:

- If a patient moves whilst in an episode of care, the patient should be given the choice to continue this episode of care with the existing service. If the patient chooses not to continue with the existing service, wherever possible, a handover with the new service should take place.
- If a patient moves whilst on the waiting list for treatment and wishes to access this treatment in the new service, the new service should consider their previous waiting list status and use clinical judgement to determine treatment priority.
- As with any patient, it is important to check their ability to maintain a focus on psychological work and for the clinician not to assume either way. If someone has problems with their accommodation/ finances/ relationship/ asylum status etc., it should not be presumed that they will not benefit from NHS Talking Therapies.
- Operational considerations such as funding and waiting list pressures should not take priority over patient choice, and/or clinical judgement.

10.3 Bite-sized Positive Practice Guides

Positive practice guides have been developed to support commissioners and providers to improve equity of experience, access, and outcomes for a number of specific underrepresented groups. Alongside these full guides, a suite of bite-sized versions has been developed (see Appendix G). These capture the key considerations and recommendations for reducing barriers to access and for adaptations that may be required for each group. They should be considered alongside wider best practice set out in this manual, to provide inclusive and equality-focused services that benefit all patients.

Below is a summary of the underrepresented groups covered within these guides.

10.3.1 Long-term physical health conditions (LTCs)

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

10.3.2 Perinatal mental health problems

Undiagnosed depression and anxiety disorders can seriously impact on the health and wellbeing of the mother and baby during pregnancy and the postnatal period. Therefore, it is recommended that women in the perinatal period are prioritised for assessment within 2 weeks of referral and commence treatment within 4 weeks. The current guidance sets out key important considerations as outlined in the Antenatal and Postnatal Mental Health NICE guideline, and provides further information on understanding the needs of parents with perinatal health problems and ways in which barriers to access can be minimised.

10.3.3 Learning disabilities

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

10.3.4 Autism

Autistic people (approximately 1% of the population) more commonly experience periods of depression and anxiety disorders. From this understanding, it would be expected that autistic people frequently access NHS Talking Therapies services for support. Neither a diagnosis of autism nor awaiting an autism assessment should prevent people from receiving treatment in NHS Talking Therapies services. Recent research shows that such individuals can benefit.[30] However, it is recognised that services may experience challenges in achieving equitable outcomes. In order to assist services to provide the appropriate environment for autistic individuals to achieve maximum benefit, a Positive Practice Guide has been developed which clarifies special considerations and suggests reasonable adjustments.

10.3.5 Attention Deficit and Hyperactivity Disorder (ADHD) and other neurodivergence

There is not currently a positive practice guide on this topic. NHS Talking Therapies Services provide NICE recommended treatment for depression and multiple anxiety disorders. Services must ensure equitable access for people with ADHD and other neurodivergence and embed neuro-culturally competent approaches across all stages of care - from engagement to discharge. Clinicians must distinguish between mental health issues and neurodivergent traits to prevent harm, drawing on specialist knowledge in the team as required. To allow tracking of outcomes, clinicians should record ADHD in the patient record whether this is based on a formal diagnosis or the patient's own self-identification. Clinicians should be aware of common co-occurrence of autism and ADHD. Therapists should avoid promoting masking or neuro-normative expectations and instead empower individuals to live authentically, reflecting their neurotype. Therapeutic interventions should be adapted appropriately in line with evidence-base. Adaptations to therapy should be collaboratively agreed, not assumed. These may include adapting environment, communication and therapeutic methods to meet individual processing and sensory needs.

10.3.6 Veterans

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

10.3.7 Offenders

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

10.3.8 Older people

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

10.3.9 Black, Asian and Minority Ethnic service users

People from ethnically and culturally diverse communities have traditionally been underrepresented in NHS Talking Therapies services, and for most groups their clinical outcomes are worse compared with people from white British backgrounds. Every service should take robust anti-racist and inclusion action to tackle and overcome these disadvantages. This guide covers key factors to improve equity of access and outcomes for people from ethnically and culturally diverse communities.

10.3.10 Working with people who use drug and alcohol

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

10.3.11 Working with LGBTQ+ people

LGBTQ+ individuals are often sceptical of mental health services and are concerned that practitioners will not be aware and understanding of LGBTQ+ considerations. This Positive Practice Guide and Bite-sized Positive Practice Guide provides practical recommendations to support therapist/practitioner competence and confidence in working with the LGBTQ+ community.

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

10.4 Key aspirations

Equity of access and outcomes for all will be achieved when:

- the proportion of patients using NHS Talking Therapies services is in line with both prevalence and the local community profile
- a diverse group of people choose to access psychological therapies to improve their mental health
- clinical outcomes are unaffected by age, race, religion or belief, sex, sexual orientation, disability, marital status, pregnancy and maternity, or gender reassignment.

11 Working with the wider system: improving care

11.1 The need to work with others

There's a growing move towards delivering care in an integrated way that ensures a patient's mental and physical health needs are met in the same care pathway. Patients consistently report that integrated care is preferred. It is also more cost effective, utilising resources more effectively and getting patients to the right treatment, at the right time with the right support.

The Five Year Forward View for Mental Health introduced whole-person care that responds to both physical health and mental health. This is supported by the NHS Long-Term Plan which built on the provision of genuinely integrated care for patients at the point of delivery. The NHS Major Conditions Strategy Case for Change calls for this integrated approach to mental and physical healthcare to be extended and embedded across a range of care pathways.

Mental and physical healthcare are often delivered by separate services that are often not coordinated. This is inconvenient for patients, costly to the NHS, and likely to produce sub-optimal clinical outcomes. Therefore, it is good practice for NHS Talking Therapies for anxiety and depression services to be designed and embedded as part of a wider system.[25] Working collaboratively with the wider system will facilitate a positive experience of the journey through the pathways and improve health outcomes.

11.1.1 Co-production with experts by experience

Co-production with experts by experience is an essential component of delivering high-quality NHS Talking Therapies services.

System leaders should plan and develop NHS Talking Therapies services through collaboration with the people who need and use the services, their families and carers in the role of experts by experience. In addition, there should be collaboration with representatives of the local population. This will help to ensure that the needs of patients and the wider community are adequately reflected in service design and provision.

Experts by experience can be broadly defined as individuals, family, friends, and carers who have experience of mental and physical health difficulties (or of caring for somebody who does) and who have accessed NHS mental health services as a result of these difficulties.

Working with experts by experience acknowledges that lived experience is as valuable as clinical/ professional expertise. Working in partnership enhances the learning and practice of health professionals and the delivery of better outcomes for those who use services.

The Carers Trust has published a guide to best practice for including carers in healthcare.

See the NHS England website for more information about the importance of working in partnership with experts by experience and communities.

11.1.2 NHS Talking Therapies sits within a wider landscape of service provision

Working with the wider system is essential to deliver on the ambition of integration and calls for systems leadership. Commitment from systems and provider organisations is critical to influence change and organisational behaviour, creating transformation within the wider system and improving outcomes for patients.

It is important for NHS Talking Therapies services to be embedded within local care pathways, ensuring clarity about who is seen, when, and where to make referrals to other services that may more appropriately meet the individual's needs. Local discharge and onward referral policies need to be developed to support people as they recover.

Social prescribing

Social prescribing is an important part of working with the wider system, facilitating an important link for patients with non-medical sources of support within the community. A number of social prescribing interventions are included within the range of NICE-recommended psychological interventions, such as bibliotherapy and personal skills development.

Social prescribing can support NHS Talking Therapies service delivery through:

- increasing access to a broader range of psychosocial interventions
- increasing the range of providers, including voluntary and community involvement
- increasing capacity to respond at an earlier stage
- forming part of a comprehensive relapse prevention package.

See the NHS England website and the social prescribing workspace on the FutureNHS platform for more information.

Physical activity

Research by Sport England[w] recognises the important role that physical activity plays in improving outcomes for people with common mental health conditions. In addition, group based physical activity is a NICE recommended intervention as a part of treatment for depression at all levels of severity.[x] NHS Talking Therapies services are well positioned to support patients to overcome barriers, such as motivation.

Emphasis should be placed on enabling patients to move more within the limitations of their health, embedding a greater focus on physical activity in treatment plans and shifting away from the common association of physical activity as 'exercise'. To support people to move more (including those living with long-term physical health conditions), it is important patients do an activity that is enjoyable, start slowly – building up if appropriate, and gradually, and make the most of good days. Approaches should align with existing NHS Talking Therapies provision by aiming to be inclusive and focus on integrating patients into their community. Active Partnerships across England are well placed to connect NHS Talking Therapies services with suitable local physical activity provision.

See the Transformation Partners in Health and Care website for more information and NHS Futures for related webinars.

[w] https://www.transformationpartnersinhealthandcare.nhs.uk/iapt-transformation/working-with-partners/sport-and-physical-activity/

[x] https://www.nice.org.uk/guidance/ng222/chapter/Recommendations#treatment-for-a-new-episode-of-less-severe-depression

11.2 NHS Talking Therapies for people with long-term physical health conditions (LTCs) and/or medically unexplained symptoms (MUS)/ persistent physical symptoms (PPSx)

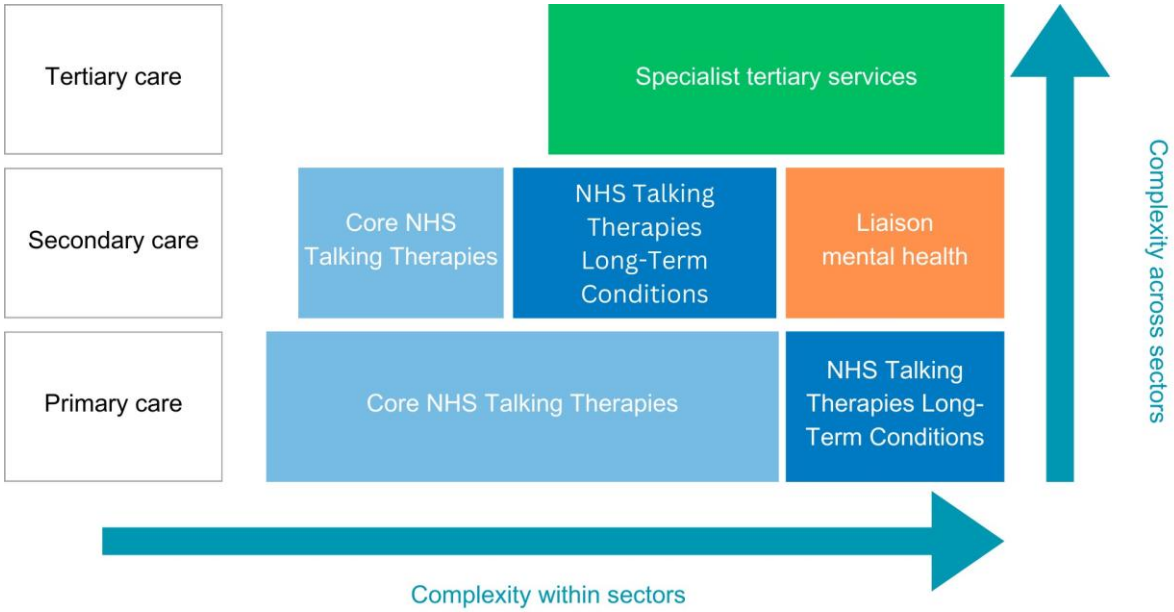
In 2018, NHS England issued The Improving Access to Psychological Therapies (IAPT) Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms: Full implementation guidance. Four in ten people accessing NHS Talking Therapies services have a coexisting long-term physical health condition.

Integrating mental and physical healthcare can ensure a **more proactive approach to mental health** by reducing stigma and promoting mental health awareness. It will allow **faster treatment**, due to the co-location of services reducing barriers and more **effective treatment** due to better understanding of coexisting physical health problems and better tailored care plans.

Workforce integration (as described in the implantation guidance) is critical to the success of NHS Talking Therapies for LTCs and MUS/ PPSx, through skill-sharing and treating the 'whole person' to optimise outcomes. This will help overcome barriers to the recognition and treatment of mental health problems in people with a comorbid LTC or MUS/ PPSx (such as diagnostic overshadowing, presenting with physical symptoms only, and the time pressures that physical health teams are under).

Underpinned by core NHS Talking Therapies principles and standards, NHS Talking Therapies services are required to develop and deliver integrated pathways with physical healthcare services.

Figure 8: Integrated delivery of care



11.3 Primary care interface

Close liaison with primary care is essential for the success of NHS Talking Therapies. It is hoped that each GP practice will identify a lead who will champion the NHS Talking Therapies service. These leads should have a named counterpart in the NHS Talking Therapies service to facilitate the close working links required. Collaboration should take place with GPs over the management of medication, so that it facilitates rather than hinders psychological therapy. Co-location in GP practices can improve integration with primary care, supporting a more joined-up approach for people using NHS Talking Therapies services. Where this is not possible, links with primary care should be developed for all people using NHS Talking Therapies services. This is important to manage risk effectively through enhanced communication mechanisms and collaboration.

As part of the Additional Roles Reimbursement Scheme (ARRS), a range of Mental Health Practitioners are being deployed directly into GP practices. Psychological treatments for anxiety and depression should be provided by practitioners who are part of the NHS Talking Therapies service.

11.4 Mental health service integration

Systems leadership, developing a shared vision and clear strategic direction can support mental health service integration. One example of achieving better integration is shared clinical leadership spanning primary and secondary care services. If this is not in place, effective and reciprocal links can still be established with specialist mental health services to ensure that timely transition across services is achieved when necessary. This includes psychological support for people with more complex needs and enduring conditions, and counselling services for people needing emotional support but not primarily experiencing depression or anxiety disorders. Building relationships with the voluntary and community sector that offer a range of mental health services is an important part of developing local care pathways.

See guidance to improve joint working between NHS Talking Therapies and Community Mental Health services on the FutureNHS platform.

11.5 Employment support

There are poorer employment outcomes for people with coexisting mental and physical health problems. There is a high risk of dropping out of the labour market, unemployment, absenteeism, and poorer performance.[28] It has been established that the longer people are absent, or out of work, the more likely they are to experience depression and anxiety[y]. Therefore, employment advice, delivered as a core part of an NHS Talking Therapies service, is integral to the success of that service.

NHS Talking Therapies therapists work alongside employment advisers (EAs), to provide combined psychological treatment and employment support. For this reason, the original NHS Talking Therapies Service Model stated that each team should include one EA for every eight therapists[3]. We would expect about 15% of people who complete NHS Talking Therapies treatment to take up combined treatment and employment support. Employment advice, money guidance and other social assistance should be available within the NHS Talking Therapies service and offered as part of an integrated care plan with close liaison

[y] Rising ill-health and economic inactivity because of long-term sickness, UK - Office for National Statistics

between clinicians and EAs from the point of assessment, through treatment and to discharge.

EAs in NHS Talking Therapies provide practical advice and relevant interventions to help individuals gain and retain employment. There is employment advice in the NHS Talking Therapies service model and there is scope to adapt aspects of service delivery at a local level.

Senior EAs ensure that employment support is embedded within NHS Talking Therapies services and the work of EAs is sufficiently integrated with relevant employment bodies at a local level. This includes building relationships with Jobcentre Plus, Connect to Work, WorkWell, and other relevant employment support providers, as well as local chambers of commerce, training providers and local employers.

Employment Support is available to all NHS Talking Therapies patients who can start employment support at the initial assessment, during treatment, or for a short period following discharge. EAs support clients to identify their employment goals and support them to create personalised plans setting out the actions required to reach their goals. They provide information, advice and guidance to support them to realise these goals.

EAs work with clients to improve their CVs, improve their interview performance, and provide careers guidance to help them access education and training to support their career aspirations.

EAs are trained to support clients to obtain three key outcomes:

- To gain employment for those who are out of work
- To get back into work for those who are on sick leave
- To stay in work whilst they go through treatment for those who are in work and working.

As well as supporting clients to obtain the key outcomes, EAs are trained to support clients to move closer to the labour market. For example, by helping clients take up volunteering opportunities and/or training and education courses to improve their chances of finding a job that they aspire to.

In addition to providing employment support EAs provide the following advice and guidance to people who experience social and economic stressors that make it difficult for them to work:

- Guidance on claiming benefits
- Money Guidance (not money advice) to support clients to manage their finances more effectively
- Signposting those who require debt counselling to a local accredited debt service
- Signposting to Food Banks and community food outlets
- Signposting to social housing providers if clients are in housing need
- Signposting to organisations that can provide them with representation including trade unions, law centres and employment lawyers.

There is evidence from Process Evaluation published in July 2019 and client research published in May 2022 that suggests that the provision of employment support benefits NHS Talking Therapies services in several ways:

- Allows therapists to concentrate on providing treatment rather than having to provide employment support
- Improves engagement in treatment and increases chances that clients will complete treatment
- Increases clinical improvement and reliable recovery rates

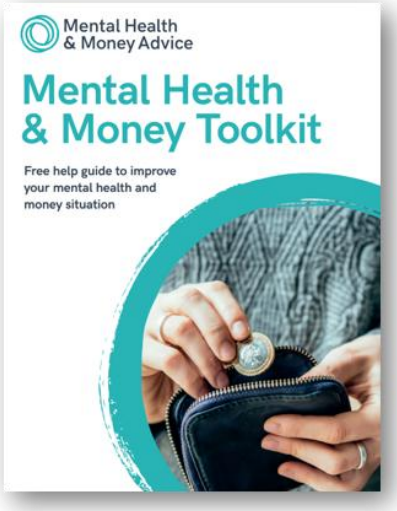
The Employment Advisers Data Handbook for Version 2.1 of the IAPT Data Set has been developed and to aid clinicians, data leads and EAs with their data submissions. It covers collection of employment and non-employment data items, how to submit the data, and why the inclusion is important.

11.6 Money worries and debt advice

There is a strong interrelationship between struggling with money and mental health problems. Mental health problems can make it harder for people to manage money or can lead to overspending. Where someone's ability to work is impacted, this can lead to a reduction in income and the onset of money worries. In turn, worrying about money problems often has an impact on mental wellbeing.

Where problems escalate, the link between mental health problems and debt is well established. Research conducted by the Money and Pensions Service (MaPS) found that 56% of clients supported by MaPS-funded debt advice services in 2018/19 had been diagnosed with a mental health problem. The Money and Mental Health Policy Institute state that 46% of people in problem debt also have a mental health problem, and that being in debt impacts on recovery. For example, people with depression and problem debt are four times more likely to still have depression 18 months later compared with people not in financial difficulty.

The Mental Health and Money Advice service was funded by the Department of Health and Social Care (DHSC) to produce a resource to support people to manage both their mental health and money difficulties.



The Mental Health & Money Toolkit was co-produced with the National Academy for Social Prescribing, healthcare professionals and people with mental health and money worries.

It contains a range of CBT-informed exercises to support people to face their debt challenges and build self-esteem, plus some key money guidance information, including an income and expenditure sheet and how to access free debt advice. Clinicians can work through the toolkit with patients, or it can be used by patients on their own.

MaPS and the Office for Health Improvement and Disparities (OHID) have developed a bite-size eLearning course for healthcare professionals about financial wellbeing. It covers the links between our health and money, practical actions frontline healthcare professionals can take, and a range of useful resources. It advocates a Very Brief Intervention model - Ask, Assist, Act.

11.6.1 How NHS Talking Therapies can help patients to access independent debt advice

NHS Talking Therapies staff should encourage patients to seek free debt advice if this is identified as a need.

The government funded independent Money Helper website, run by MaPS has a range of advice and tools, including the Money Helper Debt Advice Locator Tool. Staff can use the tool or signpost patients to it to find details of either online, face-to-face, or telephone debt advice providers.

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

By completing a simple web referral form on the Money Adviser Network website individuals have the option to access:

- Referral to the online debt self-help tool.
- Immediate call-back from a Debt Advice Agency.
- Scheduled call-back from a Debt Advice Agency.

11.7 Student services

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

Features that should be in place to help students benefit from NHS Talking Therapies services are:

- Assessment and treatment protocols to provide students with equitable access to treatment, especially in areas with high student populations.
- NHS Talking Therapies staff being aware of the dates of student terms.
- Protocols that allow treatment to continue both during and outside of term-time (using telephone, video consultation or other internet-based sessions). The NHS Talking Therapies service, linked to the student's GP, should ensure that treatment is available throughout the full year.
- If the student has a preference for in-person treatment, NHS Talking Therapies services should have a policy of aiming to arrange the start of treatment for a student to coincide with a suitable period of time that the student will be in the locality (either their university address or their home address). If this involves any period of waiting, a risk assessment should be conducted and if appropriate an alternative arrangement agreed with the student. This might involve re-considering remotely delivered intervention or arranging for NHS Talking Therapies or other treatment to start near the student's other address.
- Agreement with universities to have information about NHS Talking Therapies services and self-referral routes available on the university campus and website.
- Collaborative arrangements with university counselling services to agree which types of mental health problems are best dealt with in-house or by the NHS Talking Therapies service.

12 Key features of a well-designed NHS Talking Therapies service

12.1 Principles underpinning the design and planning of NHS Talking Therapies for anxiety and depression

The key design principles that support best practice:

- **Right number of people seen**: understanding the level of need across local communities and maximising services to meet those needs.[29]
- **Right services**: providing effective NICE-recommended treatments within a stepped/stratified care framework, delivered by a sufficiently large, trained, and competent workforce, and informed by patient feedback wherever possible.
- **Right time**: improved timely access to services for people with depression and anxiety disorders.
- **Right results**: collecting and delivering routine outcome data about improved health and wellbeing, social inclusion and employment, improved choice and improved patient experience.

12.2 Key messages for systems

Systems should ensure that:

- There is clear, credible, accountable, and collaborative leadership in place, working closely with clinical leads for NHS Talking Therapies services and other pathway leaders.
- Self-referral is available to promote accessibility and facilitate a patient's active attempts to seek help which can lead to improved outcomes.
- Communication and marketing are ongoing and collaborative. Systems should ensure there is a strategy in place that will bring together NHS Talking Therapies providers, primary care, other relevant providers, communities, and patients to raise awareness of the service offer and promote access.
- There are targeted interventions for groups of people to promote wider access to NHS Talking Therapies, as required by the Public Sector Equality Duty of the Equalities Act (2010).
- There is integrated delivery of high- and low-intensity interventions within NHS Talking Therapies so that there is a seamless transition for patients within the stepped/stratified care model. Systems should also aim to develop coherent care pathways linking NHS Talking Therapies with other mental and physical health provision.
- A highly responsive and accessible stepped/stratified-care model exists from primary care through to acute care, and that NHS Talking Therapies has a clear, complementary fit within whole system pathways, through a well-defined NHS Talking Therapies service offer. See guidance to improve joint working between NHS Talking Therapies and Community Mental Health services on the FutureNHS platform.
- Services provide the right dose of treatment according to NICE guidelines and do not cap the number of sessions to less than NICE guidelines recommend**.** Evidence-based treatments should be given at the minimum dose that is necessary to achieve full and sustained recovery.
- The investment in service provision that is agreed within systems should reflect the realistic cost of providing effective, evidence-based treatment for patients with

varying service needs. Patients with more complex presentations will generally require more intensive treatment. The same applies to patients with PTSD and social anxiety disorder because NICE does not recommend low-intensity treatment as first choice options for these conditions. A need to involve multiple professionals (e.g., therapists and employment advisers) or to focus on the management of a long-term physical health condition (LTC) in addition to a mental health problem may also increase delivery costs.

- NHS Talking Therapies offers patients a genuine choice of treatments and methods of delivery, when NICE guidance indicates that multiple treatment options are effective.
- An appropriately trained and adequately sized workforce is in place, comprising PWPs, HITs, employment advisers, support staff, data and clinical leads.
- NHS Talking Therapies services provide an NHS Talking Therapies-compliant supervision system for all staff, access to appropriate CPD and a clear strategy for optimising staff wellbeing and retention.
- There is investment in digital leadership and transformation to enable patients and staff to have access to available evidenced-based digital tools, considering digital solutions in line with guidance on using digital tool across the NHS Talking Therapies pathway.https://future.nhs.uk/MHRH/view?objectId=194107301

Systems and providers should also:

- Audit their alignment to the NHS Talking Therapies manual. External NHS Talking Therapies service accreditation can support this audit. The Accreditation Programme for Psychological Therapies Services builds on the standards promoted by the National Audit of Psychological Therapies, aligns the Care Quality Commission domain of quality, and incorporates NHS Talking Therapies specific quality standards that are aligned to the Manual. Services measuring against the Accreditation Programme for Psychological Therapies Services standards can identify areas of strength to share good practice, as well as areas to improve.
- Use a values-based commissioning approach to merge patient and carer perspectives, clinical expertise and evidence-based approaches when designing NHS Talking Therapies services.
- Develop a comprehensive understanding of local demographics, patterns of service consumption and flow across health and social care services in order to plan NHS Talking Therapies provision that meets local need.
- Continually and collaboratively monitor, review, and refine local NHS Talking Therapies provision across the whole system pathway, especially during periods of wider service redesign that might impact on NHS Talking Therapies delivery.

12.3 A good NHS Talking Therapies service

Systems have a significant role to play in better performing services, ensuring the right level of investment, monitoring, and discussion of outcomes, and avoiding perverse incentives. The Care Quality Commission (CQC) assesses services against several specific domains (see Table 11), and it is good practice for NHS Talking Therapies services to work towards meeting the benchmarks set out within this framework.

Table 12: Summary of what a good NHS Talking Therapies service looks like against CQC domains

CQC domain	Key features of a better performing NHS Talking Therapies service
Well-led	• **Effective leadership**: creating a culture of shared leadership through staff engagement, effective teamwork and accountability, with patients held firmly at the centre • **Values driven**: leaders displaying the values of the NHS through their behaviour, engaging stakeholders, delivering person-centred coordinated care and focus on staff wellbeing • **Clear strategic direction**: delivering an inspiring vision and alignment of objectives at every level • **Outcomes-focused**: ensuring a high-quality service providing the best possible standards of care for everyone in the local community • **Engage and empower others**: able to hold the key characteristics of the national NHS Talking Therapies programme while meeting local need within rapidly changing landscapes and working within the wider system to empower communities • **Value for money**: Focusing on productivity. Balancing effective, efficient service delivery with recovery-focused compassionate care • **Building leadership capability**: Inspiring leadership development through promoting attendance at NHS leadership courses, NHS Talking Therapies regional leadership workshops and local leadership development forums • **Focus on innovation, research and the digital agenda**: to design service models that deliver best practice within evidence-based interventions and offer more choice, allowing staff to thrive within an innovation environment.
Effective	**The right therapy:** • A choice of evidence-based, NICE-recommended therapies based on accurate problem descriptors. For depression, the choice of therapies extends to beyond CBT approaches to include interpersonal therapy, brief psychodynamic therapy, couple therapy and person-centred experiential counselling for depression[3]. For PTSD, the choice of therapies is Trauma-focused CBT or EMDR. • Following a prompt and good assessment, allocation to an appropriate low-intensity or high-intensity treatment. Progress should be carefully monitored with people being stepped up from low-intensity to high-intensity treatment if the initial response is inadequate • Services should have written good practice guidelines for staff to support clinical decision-making and appropriate stepping between treatments • **Session-by-session outcome measures** are a key characteristic of an NHS Talking Therapies service and provide an outcomes framework for performance management to drive quality improvement. This level of transparency helps to understand how effective the NHS Talking Therapies service is, as well as identify contracts that provide good value for money.

CQC domain	Key features of a better performing NHS Talking Therapies service
	Meeting the national standards • Achieving the required reliable recovery rate • Achieving the required reliable improvement rate • Meeting the courses of treatment measure • Achieving the waiting time standard of 75% of people starting their course of treatment within 6 weeks of referral and 95% within 18 weeks • Minimum of 95% data completeness for pre/ post-treatment scores for both depression and anxiety/ MUS measures. **Best practice:** • Most patients seen in the service go on to have a course of treatment (2 or more treatment sessions) • Problem descriptors are identified for all patients at the initial assessment interview • All patients with a specific anxiety disorder have their outcomes assessed with anxiety disorder specific measures (ADSMs) or MUS measures • Patients are allocated to the right type and level of treatment first time • Patients receive an adequate dose of therapy in line with NICE guidance. **Continuous quality improvement:** • Data-informed service-level reflective practice. Curious about data, analysing themes and patterns and using this intelligence to improve outcomes • Local quality improvement strategies implemented, based on local areas of development identified through qualitative and quantitative data • Engaging staff and patients in shaping quality improvement • Improving equality of access and outcomes for all • Ensuring national reports reflect local performance through data quality validation including national and local data alignment • Actively involved in research with good relationships with local universities.
Safe	**The workforce:** • Key focus on staff wellbeing • Appropriate number of trained staff • Appropriately qualified supervisors delivering outcomes-focused weekly supervision • Staff receive personalised feedback benchmarked against the service average or other clinicians • Tailored CPD • The right skills mix and level of experienced clinicians • A diverse workforce that reflects the local population and is culturally competent • Professional registration and accreditation • Workforce stability, retention and sustainability planning. **Supporting safe therapy:**

CQC domain	Key features of a better performing NHS Talking Therapies service
	• Robust local systems that enable analysis of all outcomes, including reliable deterioration • Ensuring a good assessment to support the right evidence-based therapy is chosen in line with the accurate problem descriptor, using outcome measures, supervision and review as a corrective function. **Integrated governance:** • This should be supported by effective data management systems that facilitate routine data collection and analysis. Data analysis should support timely feedback at clinician and service level, with service-level outcomes published • Performance management systems are important to ensure accountability, productivity and improving outcomes • Services should develop their own standard operating procedures to ensure data quality and validation (as local and national data must be aligned) • Local reporting capability is essential for reflective practice at individual, team and service level to promote a culture of enquiry • Local missed appointment policies and best practice guidance on attrition, as services should make strenuous efforts to assertively contact both new referrals and people that have lost contact during a treatment episode • Use of audit.
Caring	**The person held firmly at the centre of care:** • Focus on holistic care with a commitment to empowering patients at the centre, to improve mental health and wellbeing, social inclusion and employment, improved choice and access and improved patient experience. **Patient feedback and engagement:** • Individual feedback through completion of patient experience questionnaires (PEQs) • Implementing changes and learning from feedback and complaints • Engagement in service design, service development and service improvement. **Focus on staff wellbeing:** • A culture of shared and compassionate leadership providing high levels of support to staff • Clear objectives should be set for all staff, encouraging accountability and leadership at all levels • Development opportunities should be provided, accompanied by a high level of supervisory support • Provide and review training opportunities, tailored CPD and weekly outcomes-focused supervision • Special interest groups to enhance skills • Provide career development opportunities for all staff • Team building to support effective teamwork • Wellbeing champions to promote wellbeing activities.
Responsive	**Accessibility:**

CQC domain	Key features of a better performing NHS Talking Therapies service
	• Simple and direct access that is not hindered by complex patient opt-in or confirmation systems • GP referral and self-referral • Seek to engage underserved groups to improve access and outcomes for all • Choice of location and able to offer home visits where appropriate • Clear and continuous publicity for the service to promote access: user-friendly and engaging websites, service leaflets, posters and other promotional materials developed and regularly updated. **Importance of choice: flexibility to fit with individual need** • If treatments are similarly effective a choice of therapy should be offered in line with NICE guidelines • Choice of how therapy is delivered (one-to-one, group or blended therapy) where appropriate • Choice of gender, ethnic or cultural background, and/or religion of the clinician, where this is practical. The provider will ensure the patient has access to an interpreter or British Sign Language signer when necessary • Flexibility in terms of appointment times and location as well as contact via telephone, internet and email • Have **built-in flexibility** around working times and when and where to offer additional appointments, such as evening and weekend clinics. **Working with the wider system:** • Shaping integration within the wider system to improve a patient's experience and outcomes at a local level. • Integration within primary care and GP champion • Links with other services, such as housing, debt, social care, third sector and charitable organisations • Employment advisers in the team to support individuals who are receiving treatment, and who work with employers to help people gain or retain employment • The services should offer psychological therapies for complex cases, but have the skills to identify when other support should be brought in • Connected, as part of a whole pathway approach, with the wider system, to facilitate a positive experience of care throughout.

Definitions of terms and abbreviations

Definitions of terms

Term	Definition
Course Accreditation	In the NHS Talking Therapies context, course accreditation with a recognised professional organisation indicates that the training programme has undergone a process of scrutiny to ensure that its curriculum, teaching materials, staffing, resources, management and governance structures have met the necessary national curricula requirements as agreed and laid down by the NHS Talking Therapies programme.
Caseness	A patient is said to be at caseness when their symptom score exceeds the accepted clinical threshold for the relevant measure of symptoms. For the PHQ-9, this is a score of 10 or above. For the GAD-7, this is a score of 8 or above. Other symptom measures, such as those used to measure the severity of different anxiety disorders, have their own specific thresholds. Some outcome measures (such as the WSAS) do not have recommended caseness thresholds but provide valuable additional information about the quality of a treatment response.
Long-term physical health conditions (LTCs)	A range of long-term physical health conditions such as cardiovascular disease, COPD, diabetes and musculoskeletal disorders.
Medically unexplained symptoms (MUS), also known as Persistent Physical Symptoms (PPSx)	Persistent physical symptoms that are distressing and disabling but cannot be wholly explained by a known physical pathological cause.
Problem descriptor	A way of describing a patient's presenting mental health problems as assessed by an NHS Talking Therapies service (previously referred to as a 'provisional diagnosis'). The descriptor corresponds with ICD codes and captures information on the nature, severity and duration of symptoms, and their impact on functionality. A problem descriptor is used to support identification of appropriate NICE-recommended treatment options. It is recognised that people may have more than one mental health problem. For this reason, services can enter several problem descriptors. The primary problem descriptor should reflect the treatment being delivered.
Recovery	A patient moves to recovery if their symptoms were considered a clinical case at the start of their treatment (that is, their symptoms exceed a defined threshold as measured by scoring tools) and not a clinical case at the end of their treatment.
Reliable improvement	A patient has shown reliable improvement if there is a significant improvement[z] in their condition following a course of treatment, measured by the difference in their first and last score.

[z] As such, the difference in scores is not attributed to chance.

Term	Definition
Reliable recovery	A patient has 'reliably recovered' if they meet the criteria for both recovery and reliable improvement.
Stepped care	A model of care where people start with the least intensive effective intervention and move to more intensive support only if needed, based on ongoing monitoring. This model is used for most patients in NHS Talking Therapies.
Stratified care	A model of care in which people are matched to the level or type of intervention appropriate to their specific needs from the outset, based on complexity, or predicted response to treatment. This model is used for specific types of presentation in NHS Talking Therapies. NICE Guidance sometimes uses the term "matched care" which is a closely related concept.

Stepped-care services:	
Step 1	Primary care.
Step 2	Low-intensity service: less intensive clinician input, includes guided self-help and digitally enabled therapy.
Step 3	High-intensity service: usually weekly one-to-one sessions with a suitably trained therapist, also includes CBT group work or couple therapy for depression.

Abbreviations

ADSM	Anxiety disorder specific measure
APMS	Adult Psychiatric Morbidity Survey
AFV	Armed Forces Veteran
BABCP	British Association for Behavioural and Cognitive Psychotherapies
BAMBA	British Association of Mindfulness-Based Approaches
BCT	Behavioural couple therapy
BIQ	Body Image Questionnaire
CBT	Cognitive behavioural therapy
CFQ	Chalder Fatigue Questionnaire
COPD	Chronic obstructive pulmonary disease
CPD	Continuing professional development
CQC	Care Quality Commission
CTfD	Couple Therapy for Depression
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th edition
EMDR	Eye Movement Desensitisation and Reprocessing
FAQs	Frequently asked questions
GAD-7	Generalised Anxiety Disorder Scale – 7 items
GP	General practitioner
HCPC	Health and Care Professions Council
IBS	Irritable bowel syndrome

ICD-10	International Statistical Classification of Diseases and Related Health Problems 11th edition
IPT	Interpersonal psychotherapy
IT	Information technology
LGBT	Lesbian, gay, bisexual and transgender
LTC	Long-term physical health condition
MBCT	Mindfulness-Based cognitive therapy
MI	Agoraphobia-Mobility Inventory
MUS	Medically unexplained symptoms
NCCMH	National Collaborating Centre for Mental Health
NICE	National Institute for Health and Care Excellence
NHS Talking Therapies-LTC	NHS Talking Therapies services for people with long-term physical health conditions and medically unexplained symptoms
OCD	Obsessive-compulsive disorder
OCI	Obsessive-Compulsive Inventory
PCE-CfD	Person-centred experiential counselling for depression
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
PTL	Patient Tracking List (or Patient Target List or Priority Tracking List)
PTSD	Post-traumatic stress disorder
PWP	Psychological wellbeing practitioner
RCT	Randomised controlled trial
SPIN	Social Phobia Inventory
UCL	University College London
WTE	Whole-time equivalent
WSAS	Work and Social Adjustment Scale

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Appendix A: Qualifications and accreditations

The following table details the recognised qualifications and individual accreditations for clinicians in NHS Talking Therapies for anxiety and depression services.

Therapy type	Explanation of NICE-recommended therapy type	NHS Talking Therapies training curriculum	NHS Talking Therapies training entry requirement	Training accredited by	Required post-training individual accreditation	Practitioners must have the following to practice:
Guided self-help based on the principles of CBT	Low-intensity guided self-help interventions based on CBT principles, demonstrated to be effective for depression and most anxiety disorders.	National Curriculum for Psychological Wellbeing Practitioner Programmes (v.4.3).	Graduates of any discipline who can demonstrate that they meet the academic requirements of a post graduate level qualification. Those without a degree, undertaking the level 6 Graduate Diploma within or outside of the apprenticeship route, require relevant experience and qualifications	BPS.	BABCP or BPS Registration as a PWP.	Accredited NHS Talking Therapies PWP training and individual BABCP or BPS registration as a PWP.
Cognitive behavioural therapy (CBT)	A range of specialised CBT protocols demonstrated to be effective in the treatment of depression and anxiety disorders, including PTSD.	National Curriculum for High-Intensity Cognitive Behavioural Therapy Courses (v.4).	Core Profession or Knowledge Skills and Attitudes portfolio as outlined by the British Association for Behavioural and Cognitive Psychotherapies (BABCP).	BABCP (Level 2 accredited as an NHS Talking Therapies programme	BABCP registration as a CBT Therapist (BABCP Accredited CBT Therapist).	Accredited NHS Talking Therapies CBT training and individual BABCP registration as a CBT Therapist **OR** Individual BABCP accreditation as a CBT Therapist

Therapy type	Explanation of NICE-recommended therapy type	NHS Talking Therapies training curriculum	NHS Talking Therapies training entry requirement	Training accredited by	Required post-training individual accreditation	Practitioners must have the following to practice:
						alone achieved through training and experience with adults with anxiety and depression.
Person-Centred Experiential Counselling for Depression (PCE-CfD)	A specific person-centred type of counselling that has been demonstrated to be effective in the treatment of depression.	National Curriculum for Counselling for Depression[aa]	NHS Talking Therapies recognised counselling or psychotherapy accreditation[bb] OR Health and Care Professions Council (HCPC) registered practitioner psychologist.	BACP.	NHS Talking Therapies recognised counselling or psychotherapy accreditation[bb] OR HCPC registered practitioner psychologist.	Accredited NHS Talking Therapies PCE-CfD training and individual NHS Talking Therapies recognised counselling or psychotherapy accreditation.
Couple therapy for depression	Couple therapy demonstrated to be effective in treating depression experienced by one or both partners in the context of relationship difficulties.	National Curriculum for Couple Therapy for Depression (CTfD)[aa]/ Curriculum for Behavioural Couple Therapy (BCT) for Depression.	**CTfD curriculum:** NHS Talking Therapies recognised counselling or psychotherapy accreditation[bb] OR HCPC registered	Tavistock Relationships/ BABCP.	**CTfD curriculum:** NHS Talking Therapies recognised counselling or psychotherapy accreditation[bb]/ HCPC registered	Accredited NHS Talking Therapies CTfD/ BCT training and NHS Talking Therapies recognised individual counselling or psychotherapy

[aa] Can also train via a pathway in the NHS Talking Therapies for Anxiety and Depression Psychotherapeutic Counselling pilot.

[bb] NHS Talking Therapies recognised counselling or psychotherapy accreditations comprise the following SCoPED B and C practitioner registrations: British Association for Counselling and Psychotherapy (BACP) Accredited; United Kingdom Council for Psychotherapy (UKCP) Registered as a Psychotherapist or Psychotherapeutic Counsellor; Association of Christian Counsellors Accreditation; National Counselling Society Accredited Professional registrants, British Psychoanalytic Council Registered

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Therapy type	Explanation of NICE-recommended therapy type	NHS Talking Therapies training curriculum	NHS Talking Therapies training entry requirement	Training accredited by	Required post-training individual accreditation	Practitioners must have the following to practice:
			practitioner psychologist. **BCT curriculum:** BABCP Registered as a CBT Therapist.		practitioner psychologist. **BCT curriculum:** BABCP Accredited.	accreditation.
Brief dynamic interpersonal therapy (DIT)	Brief psychodynamic psychotherapy demonstrated to be effective for treating depression. It includes a focus on difficult things in the past that continue to affect the way people feel and behave in the present.	Revised (20-day) Curriculum for High-Intensity Brief Dynamic Interpersonal Therapy (DIT)[cc] [dd].	NHS Talking Therapies recognised counselling/ psychotherapy accreditation[ee]/ HCPC registered practitioner psychologist.	British Psychoanalytic Council (BPC).	NHS Talking Therapies recognised counselling/ psychotherapy accreditation[dd] OR HCPC registered practitioner psychologist.	Accredited NHS Talking Therapies DIT training and NHS Talking Therapies recognised individual counselling/ psychotherapy accreditation.
Interpersonal Psychotherapy for depression (IPT)	IPT is a time-limited and structured therapy demonstrated to be	Curriculum for Practitioner Training in Interpersonal	NHS Talking Therapies Specified counselling/ psychotherapy	Interpersonal Psychotherapy Network UK (IPT-UK).	IPT-UK Accredited at minimum of Level B.	Accredited IPT training and individual accreditation

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

[dd] Can also train via a pathway in the NHS Talking Therapies for Anxiety and Depression Psychotherapeutic Counselling pilot.

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

Therapy type	Explanation of NICE-recommended therapy type	NHS Talking Therapies training curriculum	NHS Talking Therapies training entry requirement	Training accredited by	Required post-training individual accreditation	Practitioners must have the following to practice:
	effective in treating depression. Its central idea is that psychological symptoms, such as depressed mood, can be understood as a response to current difficulties in relationships and affect the quality of those relationships.	Psychotherapy (IPT).	accreditation[ee]/ BABCP registered as a CBT Therapist/ GMC registered Medical Psychotherapist having completed higher specialist training in psychotherapy / HCPC registered Clinical, Counselling, Educational or Forensic Psychologist or arts therapist.			(minimum Level B) **OR** Individual accreditation (minimum Level B).
Mindfulness-based cognitive therapy (MBCT)	A brief psychological therapy demonstrated to be effective in preventing relapse in individuals with a history of recurrent depression, and for alleviating current depression symptoms. Treatment is delivered in groups.	National Curriculum for Mindfulness- based Cognitive Therapy (NHS Talking Therapies MBCT).	BABCP Accredited.	British Association of Mindfulness-based Approaches (BAMBA).	BAMBA register of Mindfulness Teachers.	Recognised NHS Talking Therapies MBCT Training and on BAMBA register of Mindfulness Teachers **OR** on BAMBA register of Mindfulness Teachers **AND** have undertaken and passed an assessment of MBCT competence to an equivalent standard as required in the

Therapy type	Explanation of NICE-recommended therapy type	NHS Talking Therapies training curriculum	NHS Talking Therapies training entry requirement	Training accredited by	Required post-training individual accreditation	Practitioners must have the following to practice:
						NHS Talking Therapies MBCT training[ff]).
Eye Movement Desensitisation and Reprocessing (EMDR)	A psychotherapy model that has been developed to help people who have post-traumatic stress disorder (PTSD). People who have PTSD may experience intrusive thoughts, memories, nightmares or flashbacks of traumatic events in their past. EMDR helps to reprocess memories of the traumatic event so the negative images, emotions and physical feelings they cause reduce, leading to a change of perspective and focus on the present	National Curriculum for Eye Movement Desensitisation and Reprocessing (EMDR) with adults.	BABCP registered as a CBT Therapist / NHS Talking Therapies Specified counselling/ psychotherapy accreditation[gg]/ GMC registered Medical Psychotherapist having completed higher specialist training in psychotherapy/ HCPC registered Clinical, Counselling, Educational or Forensic Psychologist.	EMDR-Europe and EMDR-UK.	BABCP registered as a CBT Therapist/ NHS Talking Therapies Specified counselling/ psychotherapy accreditation[gg]/ GMC registered Medical Psychotherapist having completed higher specialist training in psychotherapy/ HCPC registered Clinical, Counselling, Educational or Forensic Psychologist.	EMDR-Europe Accredited EMDR Training, supervision from an EMDR-Europe Accredited EMDR Practitioner (who is in receipt of supervision from a EMDR Consultant) or an Accredited EMDR Consultant, and one of: BABCP registered as a CBT Therapist/ NHS Talking Therapies Specified counselling/ psychotherapy accreditation[gg]/ GMC registered Medical Psychotherapist having completed

[ff] NHS Talking Therapies staff who have worked continually in NHS Talking Therapies as MBCT teachers since before 1 January 2021 had the opportunity to have equivalence for NHS Talking Therapies practice recognised through BAMBA's grandparenting scheme.

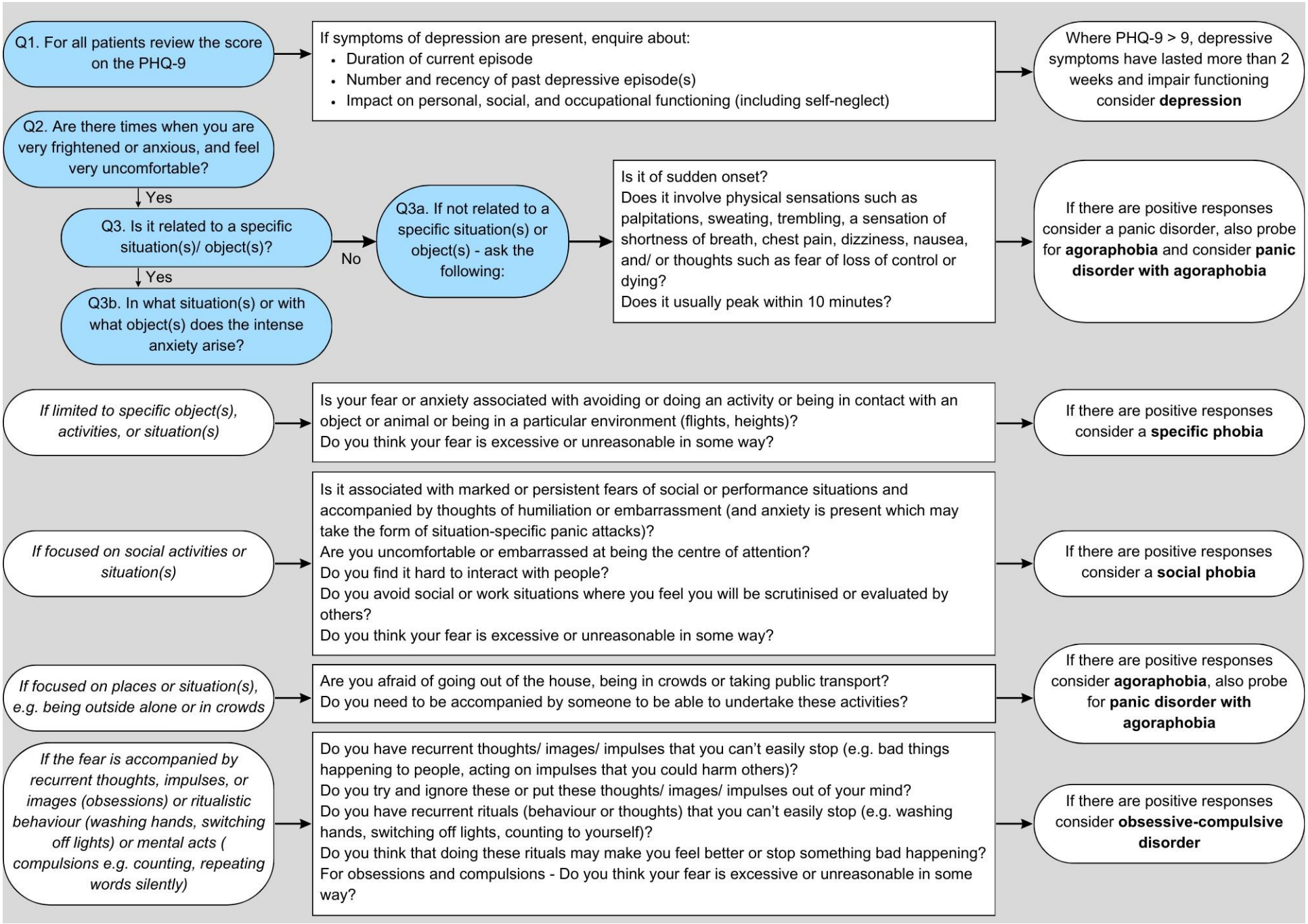
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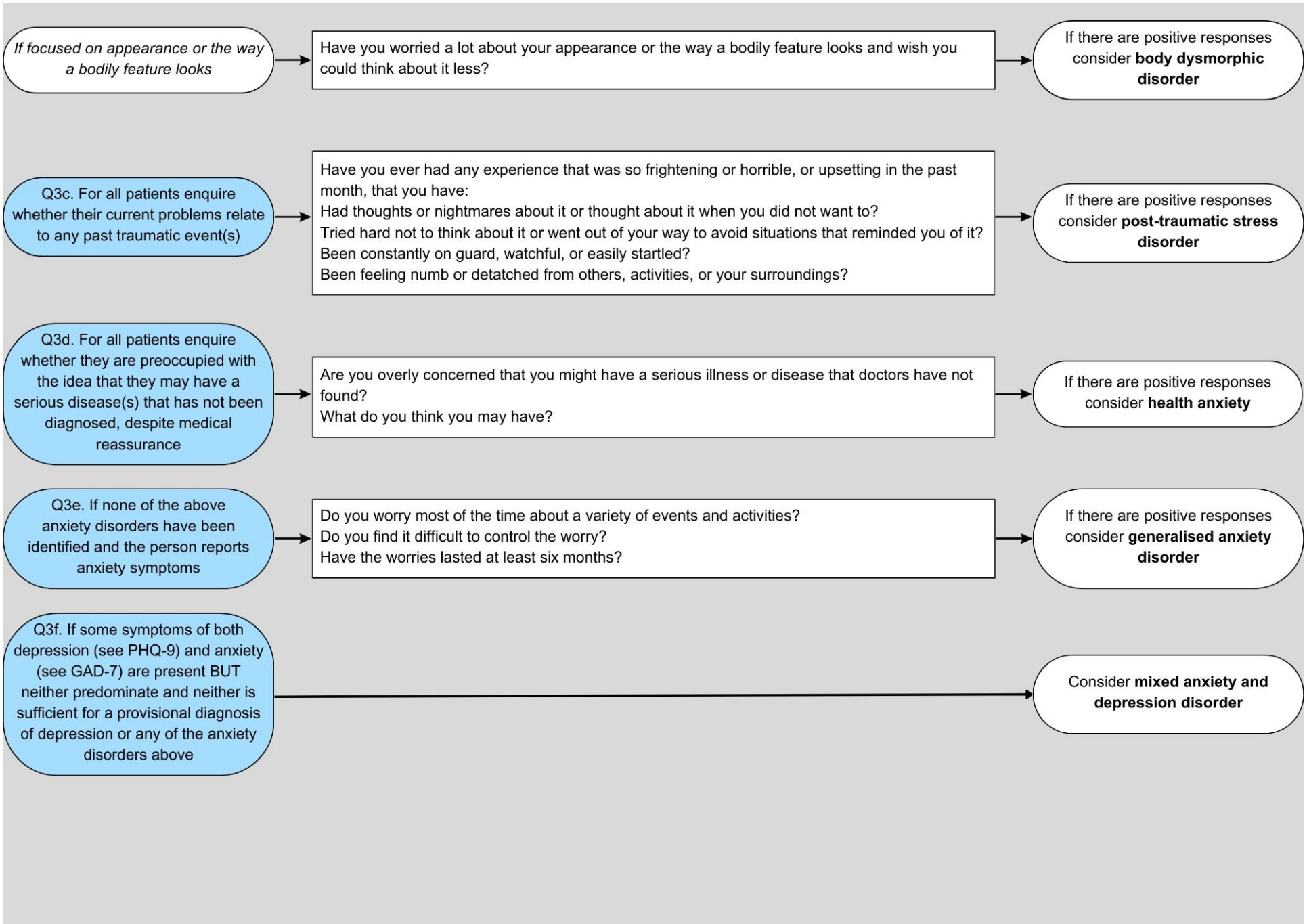
Therapy type	Explanation of NICE-recommended therapy type	NHS Talking Therapies training curriculum	NHS Talking Therapies training entry requirement	Training accredited by	Required post-training individual accreditation	Practitioners must have the following to practice:
	and future.					higher specialist training in psychotherapy/ HCPC registered Clinical, Counselling, Educational or Forensic Psychologist (see NHS EMDR Clinical Governance Guidance).

Appendix B: Screening prompts

The prompts on the following pages are recommended for use in NHS Talking Therapies for anxiety and depression intake assessments to ensure that a patient'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.

Once a clinical problem has been identified, patients should be asked to specify the year and month when they first experienced that problem in the *current* episode. This is because NICE guidance sometimes varies depending on the duration of a clinical problem.


Q1. For all patients review the score on the PHQ-9
If symptoms of depression are present, enquire about:
• Duration of current episode
• Number 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
Yes
Q3b. In what situation(s) or with what object(s) does the intense anxiety arise?
Q3a. If not related to a specific situation(s) or object(s) - 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
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 (compulsions e.g. counting, repeating words silently)
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


If focused on appearance or the way a bodily feature looks
Have you worried a lot about your appearance or the way a bodily feature looks and wish you could think about it less?
If there are positive responses consider **body dysmorphic 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 detatched 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 has 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-9) and anxiety (see GAD-7) 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 depression disorder**

Appendix C: Development team

NCCMH technical team for first version of the NHS Talking Therapies for anxiety and depression Manual

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Appendix D: Bite-sized Positive Practice Guides

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

Context and considerations

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

Reducing barriers to access

- Focus on outreach and engagement of patients and healthcare professionals
  - NHS Talking Therapies services should take time to educate patients and healthcare professionals on the links between LTCs and depression and anxiety disorders, and the benefits NHS Talking Therapies can provide those with LTCs.
  - Local engagement and outreach is essential to raise awareness of NHS Talking Therapies and build an understanding of the support it offers. This can be achieved by connecting with relevant groups, networks and organisations already working with people with LTCs.
  - Dedicated LTC outreach roles should be considered within NHS Talking Therapies services, along with other bespoke outreach initiatives.
  - Efforts should be made to ensure that people who are currently receiving treatment for LTCs in an existing general healthcare pathway are made aware of services NHS Talking Therapies can offer and can self-refer to these.

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

Adaptations to clinical practice

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

Training and resources

- The NHS Talking Therapies Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms: Full implementation guidance
- Competence Framework: Psychological Interventions with People with Persistent Physical Health Problems

To view the NHS Talking Therapies Long-Term Physical Health Conditions Positive Practice Guide, please click here

To view the NHS Talking Therapies eLearning which accompanies the LTC to-up training, please click here

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

Context and considerations

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

Reducing barriers to access

- It is important that mental health and learning disability services work collaboratively.
- Learning disability services, family members, carers and advocates can play an important role in identifying mental health problems in people with learning disabilities and should be a key part of the referral pathway into NHS Talking Therapies.
- Advertise and provide psychological therapies in ways that are acceptable and meaningful to people with learning disabilities, providing information in easy-to-understand formats.
- Work with local groups specialising in learning disability to raise awareness of NHS Talking Therapies and the support it can provide people with learning disabilities.

- Ensure people with a learning disability are involved in all aspects of service development, including clinical work and service management so that NHS Talking Therapies is as accessible as possible for this population.
- Support and train people with learning disabilities to become part of the NHS Talking Therapies workforce, benefiting both the service and patients.
- Consider creating roles for staff who are specifically trained and supervised to enable them to work with people with learning disabilities.
- Many people with formally identified learning disabilities are supported by family or paid for carers to a greater or lesser extent. Services should allow these supporters to assist in accessing and remaining engaged with services.
- Consider learning disability champions who can liaise with local learning disability services, facilitate discussions and coordinate adaptations such as training for the NHS Talking Therapies and learning disability services.

Adaptations to clinical practice

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

Training and resources

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

- Greenlight Toolkit Green_Light_Toolkit_2017.pdf (ndti.org.uk) and Greenlight Toolkit – The Audit Green Light Toolkit - the Audit (office.com)
- Download and use free easy-read CBT materials from www.ucl.ac.uk/psychiatry/cbt
- www.booksbeyondwords.co.uk produces books, eBooks and other resources for people who find it easier to understand pictures than words.
- Making health and social care information accessible (NHS England, 2015): www.england.nhs.uk/ourwork/patients/accessibleinfo-2/

- Image banks with an annual subscription can be found at: www.photosymbols.com/ and www.changepeople.org/
- www.inspiredservices.org.uk provides accessible information, specialising in easy read, Braille, audio, large print and translation services.
- www.easyhealth.org.uk/ can adapt materials into easy read format.
- Free easy read health/mental health information is available from: www.surreyhealthaction.org/

To view the Learning Disabilities: NHS Talking Therapies Positive Practice Guide please click here

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

Background and context

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

Reducing barriers to access

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

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

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

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

Considerations and adaptations to clinical practice

Adaptations to clinical practice when working with AFVs include:

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

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

Training and resources

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

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

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

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

Op COURAGE: The Veterans Mental Health and Wellbeing Service

- NHS mental health support for veterans, service leavers and reservists

BABCP Armed Forces Veterans Positive Practice Guide for use by those who provide mainstream NHS mental health services for British Armed Forces Veterans.

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

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

Context and considerations

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

Reducing barriers to access

- Services should recognise and proactively challenge negative attitudes and stereotypes of ageing which suggest older people will not benefit from support.
- Promotional material should be displayed in environments relevant to older people, for example libraries, post offices and pharmacies and so on.
- Age-relevant imagery and non-clinical language should be used in promotional material to help older people recognise that NHS Talking Therapies is an appropriate service for them.
- Services should consider appointing older people champions who will run updates for professionals on age-friendly practices.
- Services should work closely with specialist older people's organisations to share knowledge and best practice of age-friendly services.
- Older people may need additional support to access services and flexible options such as home visits, outreach in to care homes and carer presence at appointments.
- Older people visit their GPs more frequently than other age groups. Services should work with colleagues in physical health settings to encourage the use of short screening tools to help identify depression and anxiety in older people.
- Ensure strategies and staff training are in place to overcome sensory changes in older people (for example hearing impairment or visual impairment) that may act as barriers and be proactive in compensating for mobility challenges and/or frailty, so that more older people are able to access treatment facilities.

Adaptations to clinical practice

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

Training and resources

- NHS HEE (2020), 'Older people's mental health competency framework'. Available at: www.e-lfh.org.uk/programmes/mental-health-training-resources/
- NHS Shropshire CCG (2018), 'New animation highlights benefits of NHS Talking Therapies talking therapies for older people'. Available at: https://www.youtube.com/watch?v=GBQTyAQdNpQ

- START (Strategies for Relatives) resources, which can be used to support caregivers are available here: www.ucl.ac.uk/psychiatry/research/mental-health-older-people/projects/start/start-resources
- Promoting the stories of people who have experienced and benefited from psychological support. Age UK has some resources here: www.ageuk.org.uk/discover/2020/01/iapt/
- University of East Anglia, 'CBT with older people, free online course'. Available at: www.futurelearn.com/courses/cbt-older-people
- Laidlaw, K., Kishita, N., & Chellingsworth, M. (2016). Clinician's Guide to: CBT with older people, Department of Health.
- Chellingsworth, M., Kishtia, N., & Laidlaw, K. (2016). Clinician's Guide to: Low Intensity CBT with older people, Department of Health.

To view the NHS Talking Therapies Positive Practice Guide for Older People please click here.

To view the eLearning course that accompanies the positive practice guide, please click here

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

Context and considerations

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

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

Reducing barriers to access

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

Adaptations to clinical practice

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

Therapists should:

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

Services should:

- Consider and develop culturally appropriate and sensitive reasonable adjustments for particular communities with members of that community. This may include adapting language, values, metaphors and techniques.
- Invest in training staff in culturally adapted and culturally responsive therapies.
- Ensure through proactive review, recruitment, training and succession planning, that the workforce reflects the diversity of the communities served at all levels and that ethnic minority staff are supported through staff networks and have equal opportunities for career progression.

- Embed the audit tool within the short positive practice guide to support with implementation of processes to drive improvements in experience, access and outcomes for people from ethnic minority communities.

Training and resources

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

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

Additional guidance and training are also available via:

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

Translated versions of Step 2 materials are available on the FutureNHS website.

To view the NHS Talking Therapies Black, Asian and Minority Ethnic Service User Positive Practice Guide please click here

To view the eLearning course that accompanies the positive practice guide, please click here.

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

Context and considerations

- More than half the offenders in prison experience common mental health problems such as depression and anxiety.
- Post-traumatic stress disorder (PTSD) and complex trauma constitute a significant problem within prisons. Prevalence of PTSD among prisoners is considerably higher than that of the general population.
- For many offenders, prison is the first/ only stable place they may have experienced.
- Offenders are unlikely to have been registered with a GP prior to commencing their sentence.
- Women are more likely to be the primary carers of children, which can make their prison experience significantly different from men. Women also tend to be located in prisons a long way from their homes because there are fewer prisons for women. This may detrimentally effect family relationships, receiving visits and resettlement in the community.
- Many women in prison have experienced domestic violence and/or sexual abuse.
- Offenders serving lengthy sentences (of 2 years or more) are likely to be more stable geographically and located in one prison for much (or all) of their sentence.

- Offenders remanded in custody or serving short prison sentences are much more challenging to engage because they are likely to move between prison, hospital and community, as well as moving between different prisons.
- Prisoners nearing release are often not informed of the location to which they will be held on licence until close to their release date, compounding their stress levels and reducing the opportunity to proactively access community support.

Reducing barriers to access

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

Adaptations to clinical practice

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

Training and resources

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

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

To view the NHS Talking Therapies Offenders Positive Practice Guide please click here

See Treatment of Post Traumatic Stress Disorder including Complex Post Traumatic Stress Disorder: Guidance for delivery of psychological therapies.

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

Context and considerations

- Offenders and ex-offenders are particularly vulnerable to mental ill health before, during and after contact with the police, courts, prison and probation services. Many within this population have experienced a lifetime of vulnerability and encounter profound and ongoing social, economic and health inequalities.

- The mental health consequences of contact with the criminal justice system can be long lasting. Ex-offenders face barriers to returning to 'normal' life. Lasting trauma from prison experience, difficulty in gaining employment due to a criminal record, and the ongoing stigma of 'being a criminal', can lead to a cycle of worsening mental health.
- Offenders tend to come from the more deprived and socially excluded sections of our communities and have significantly higher than average healthcare needs.
- Screening for PTSD should be considered due to the high levels of trauma in this population.
- Comorbidity with substance misuse and personality difficulties should not necessarily result in exclusion from NHS Talking Therapies services. It is important that services allow treatment of anxiety and depression whatever the other diagnoses, when this anxiety and/or depression can be treated appropriately by NHS Talking Therapies (see Positive Practice Guide for Working with People who use Drugs and Alcohol and bite-sized version below).
- Literacy problems are particularly relevant for offenders.
- The incidence of mental health disorder within the offending community is higher for women, older people and those from ethnic minority groups (see Black, Asian and Minority Ethnic Service User Positive Practice Guide and Older People Positive Practice Guide).
- Improving the mental health of offenders experiencing less severe mental health difficulties represents a valuable opportunity to identify and address their wider health needs and potentially reduce re-offending rates.
- Offenders tend to access NHS Talking Therapies services with secondary symptoms. Depression, PTSD and anxiety may present as anger, self-harm, drug and alcohol misuse, sleep issues, obsessive behaviour and self-harm.

Reducing barriers to access

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

Adaptations to clinical practice

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

Training and resources

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

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

See Treatment of Post Traumatic Stress Disorder including Complex Post Traumatic Stress Disorder: Guidance for delivery of psychological therapies.

To view the NHS Talking Therapies Offenders Positive Practice Guide please click here

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

Context and considerations

- Alcohol and drug use is common amongst the adult population. It may be that an individual presenting at an NHS Talking Therapies service is using either alcohol or drugs, which may be interacting with their mental health condition, but they do not have a use disorder.
- Between 70 and 80% of patients in drug and alcohol services have common mental health conditions. A significant number of NHS Talking Therapies patients are likely to be using drugs and/or drinking at harmful levels, contributing to their mental health conditions. People experiencing drug and alcohol use disorders are more likely to also experience multiple disadvantages.
- Drug and alcohol misuse (current or historic) are not automatic exclusion criteria for accessing NHS Talking Therapies if, following assessment, it is determined that the patient would benefit from NHS Talking Therapies interventions in line with NICE guidance.
- A validated screening tool, such as ASSIST-Lite, can distinguish between use and misuse. NHS Talking Therapies services should agree the most appropriate validated screening tool with their local drug and alcohol treatment service.
- NHS Talking Therapies does not provide complex interventions to treat drug and alcohol misuse. However, if screening identifies that the individual does not have problematic use, in some circumstances it may be appropriate for the NHS Talking Therapies practitioner to offer brief advice on drug or alcohol reduction. This can also help to explore how it relates to the patient's mental health condition. See guidance in 'All Our Health'.
- If a patient is identified as potentially having a use disorder as a result of screening or is unable to attend appointments without being under the influence of drugs or alcohol, the best approach for the patient's care should be agreed with the local drug and alcohol treatment service. It may be appropriate to make an active referral to the local drug and alcohol treatment service until stability is achieved. The drug and alcohol treatment service and NHS Talking Therapies service should maintain links to determine if/ when the patient is most likely to benefit from NHS Talking Therapies

treatment. It may be possible to deliver NHS Talking Therapies alongside any treatment for drug and alcohol use, and services should work together to determine the best approach.

- People who have previously received treatment for drug or alcohol use disorders do not necessarily pose any different challenges for NHS Talking Therapies services or require a different treatment approach.
- Involvement with a drug and alcohol service should be considered an advantage to psychological therapy, as it can support or indicate a motivation to change behaviour.
- NHS Talking Therapies and drug and alcohol services should work together to address the needs of patients with co-occurring conditions. Where appropriate, this should include clear pathways and arrangements for joint case reviews or co-location of services.
- Psychological interventions within drug and alcohol services are often limited. NHS Talking Therapies may provide one of the only local resources to access psychological therapy for common mental health conditions.

Reducing barriers to access

- Many feel shame about their drug or alcohol use. It is important to maintain a non-judgemental and proportionate attitude to information about substance use, neither minimising the extent of a problem nor over-stating its significance. Holding a position of curiosity and inviting the patient to consider how their substance use might be impacting on their mental health is advised.
- Patients may be concerned about discussing a drug or alcohol problem because they fear information will be passed on to others, for example police, safeguarding and so on. It is therefore important to be clear and explicit about confidentiality and constraints around this.
- Reciprocal training between NHS Talking Therapies and the local addiction treatment service can help develop clear access, transfer, and collaborative working protocols which will, in turn, support access for this patient group.

Adaptations to clinical practice

- Engagement may be difficult for some in this patient group. As such, services need to be flexible in approach, for example tolerance of some non-attended sessions.
- As part of treatment contracting, it is good practice to specify that patients must come sober to sessions. They should also not use while engaging in anxiety-related between-session behavioural experiments as concurrent use is likely to interfere with learning and the extinction of fear. If a patient finds it difficult to attend sessions without using drugs or alcohol beforehand, they should be directed to the local drug and alcohol treatment service.
- Therapists should explore the patient's view of the relationship between their substance use and their psychological distress. This has the potential to open a constructive dialogue and help identify any function the substance use serves. However, it is important to note that in some cases it can be unsafe for the patient to stop using drugs or alcohol completely, and advice from medical professionals or drug and alcohol treatment services should be sought.
- Use of substance use diaries can help explore the inter-dependencies, particularly when integrated with thought records.
- Clinicians may feel anxious about a lack of knowledge around illicit drugs. This need not interfere with psychological work nor be a barrier to taking on drug using patients. Suspending judgement and embracing a spirit of curiosity will enable the patient to speak openly about their experiences and foster a collaborative relationship.

- NHS TTad services and drug and alcohol treatment services could also consider co-locating services to target each other's patient groups.

Training and resources

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

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

- www.dualdiagnosis.co.uk/National_e-learningHub.ink
- www.e-lfh.org.uk/programmes/all-our-health/
- elearning.rcgp.org.uk/
- neptune-clinical-guidance.co.uk/wp-content/uploads/2015/03/NEPTUNE-Guidance-March-2015.pdf
- www.alcoholics-anonymous.org.uk/
- https://smartrecovery.org.uk/
- https://ukna.org
- www.adfam.org.uk/ is a national charity working with families affected by drugs and alcohol.
- https://www.gov.uk/government/publications/assist-lite-screening-tool-how-to-use
- https://www.gov.uk/government/publications/alcohol-applying-all-our-health/alcohol-applying-all-our-health
- https://www.gov.uk/government/publications/misuse-of-illicit-drugs-and-medicines-applying-all-our-health/misuse-of-illicit-drugs-and-medicines-applying-all-our-health#core-principles-for-healthcare-professionals

To view the NHS Talking Therapies Positive Practice Guide for Working with People who use Drugs and Alcohol please click here.

D.9 Working with Perinatal Parents: Bite-sized Positive Practice Guide

Context and considerations

- Perinatal mental health problems are highly prevalent, affecting 1:5 mothers and 1:7 fathers. The impact of these problems is significant, affecting not only the parent and co-parent, but can also have long-term negative effects on the foetus and new baby's cognitive, social and emotional development.
- Rates of treating perinatal parents in NHS Talking Therapies services have historically been low relative to similarly aged individuals who are not in the perinatal period.
- Parents report this is due to several reasons, including practical and logistical barriers associated with being pregnant or having a small infant, and the stigma of being a parent and suffering from mental health problems.
- NHS Talking Therapies services should work collaboratively as part of a larger perinatal health and mental healthcare pathway.
- At point of referral, services should ask if the patient is expecting a baby or has a child under the age of 2. This should be recorded on information systems.
- Services should prioritise the treatment of parents (biological and adoptive) in the perinatal period.

- All services should have perinatal champions/ leads and therapists with allocated time (e.g., 0.1-0.2 WTE) to uphold perinatal clinical practice in their service (note this time does not include individual or group therapy but rather is for additional outreach and liaison work).
- Services should ensure that all clinical staff are aware of the clinical risks in the perinatal period and there are established procedures for escalating concerns and managing risk.
- Services should consider how perinatal health changes affect patients' responses to outcomes measures.

Reducing barriers to access

- Services should offer a range of modes/ locations of delivery around patient preferences, and these should be applied flexibly based on patient needs. First treatment contact should be offered face-to-face in-person or, if not possible, via video conference.
- Services should be child friendly, allowing infants to be present during treatment, and where feasible, also provide access to childcare.
- Services should provide active outreach to the perinatal community and parents to improve awareness and increase access.
- Services should actively support parents' ongoing engagement with treatment (e.g., following up cancellations/ DNAs) and should have flexible cancellation/ DNA policies.
- Services should offer weekly sessions to perinatal parents.
- Services should use perinatally friendly language, e.g., refer to "parent," which is inclusive of both mothers, fathers, and partners. Services should aim to be inclusive of all parents and recognise the range of ways in which "family" may be defined.
- Services should develop strong links, reciprocal communication, and referral pathways with relevant health professionals (e.g., maternity, primary care, health visiting, children's centres, specialist community perinatal mental health services and Maternal Mental Health Services (MMHS) and specialist Child and Young People Mental Health (CYMPH) services.
- Services should implement the NHS Talking Therapies Positive Practice Guide for working with Black, Asian and Minority Ethnic populations.
- Service perinatal champions/ leads should familiarise themselves with the Equity and Equality Guidance for Maternity Systems.
- Services should adapt provision to reduce the impact of stigma and discrimination on perinatal patients' access, engagement, and adherence to treatment.

Adaptations to clinical practice

- At assessment and throughout treatment, services should ask and integrate into the treatment plan how the patient's (family's) culture and traditions affect their experiences of responses to pregnancy and the postnatal period.
- Clinicians should be aware of the relationships between couples/ family dynamics, pregnancy and adjusting to having a new baby and mental health.
- Clinicians should aim to involve the patient's partner or significant source of support for at least one session, if the patient agrees it would be useful. Where conjoint sessions are the primary treatment modality, at least one session early in treatment should be individual to assess for interpersonal violence risk.
- Services should be aware of the unique impact of the neonatal experience on parents, families and relationships and take steps to improve access to support.

- Access to support can be improved by delivering provision within or as close as possible to hospitals whilst the baby is admitted and to remain flexible to the ongoing needs of neonatal families post-discharge which may include flexible service delivery locations and responding compassionately to periods of potentially high levels of distress.

Training and resources

- Involving and supporting partners and other family members in specialist perinatal mental health services: Good practice guide.

To view the NHS Talking Therapies Perinatal Positive Practice Guide please click here.

To view the NHS Talking Therapies Perinatal Competency Framework please click here.

Appendix E: Case identification tools

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

GAD-2

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

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

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

Whooley questions to screen for depression

Please answer the following questions:

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

   ☐ YES ☐ NO

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

   ☐ YES ☐ NO

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

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

Mini Social Phobia Inventory Scale (Mini-SPIN)

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

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

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

Appendix F: Outcome measures

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Patient-reported outcome measures

Table 8 shows the patient-reported outcome measures recommended for routine use in NHS Talking Therapies services.

Translations of patient-reported outcome measures

NHS England have secured agreements with the majority of outcome measure tool owners for their measure to be translated into various languages. Wherever possible approved translations of measures should be used. Using interpreters to translate measures reduces valuable clinical time and may invalidate the measure.

Validated translated measures can be accessed here:
NCCR tools and measures library - NHS England Digital
Patient Health Questionnaire (PHQ) Screeners. Free Download | phqscreeners

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

Patient Health Questionnaire – 9 items (PHQ-9)

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

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

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

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

GAD7 total score ☐

(Data item 38 in the IAPT Data Standard)

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

Work and Social Adjustment Scale (WSAS)

Work and Social Adjustment Scale (WSA)

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

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

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

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

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

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

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

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

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

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

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

Social Phobia Inventory (SPIN)

SOCIAL PHOBIA INVENTORY (SPIN) ©

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

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

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

Mobility Inventory (MI)

MOBILITY INVENTORY FOR AGORAPHOBIA

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

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

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

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

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

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

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

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

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

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

Panic attacks

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

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

How severe or intense have the panic attacks been?

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

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

a. its location

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

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

Obsessive-Compulsive Inventory (OCI)

OCI

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

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

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

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

OCI Scoring

For therapist use:

Washing	
Checking	
Doubting	
Ordering	
Obsessions	
Hoarding	
Neutralising	
Total	

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

Obsessive-Compulsive Inventory - Revised (OCI-R)

NB. *The OCI will be replaced with the shorter OCI-R in the near future following dataset and derivation updates. Both measures include subscales for different subtypes of OCD (checking, washing, mentalising etc). Some patients who are significantly impaired will have initial scores below the clinical cut-off for the total scale. These individuals should still be offered treatment if they show significant clinical problems within a subscale (for example an average score of 2.5 or above on at least one subscale).*

OCI-R

The following statements refer to experiences that many people have in their everyday lives. Circle the number that best describes **HOW MUCH** that experience has **DISTRESSED or BOTHERED you during the PAST MONTH**. The numbers refer to the following verbal labels:

0 = Not at all
1 = A little
2 = Moderately
3 = A lot
4 = Extremely

1.	I have saved up so many things that they get in the way.	0	1	2	3	4
2.	I check things more often than necessary.	0	1	2	3	4
3.	I get upset if objects are not arranged properly.	0	1	2	3	4
4.	I feel compelled to count while I am doing things.	0	1	2	3	4
5.	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
6.	I find it difficult to control my own thoughts.	0	1	2	3	4
7.	I collect things I don't need.	0	1	2	3	4
8.	I repeatedly check doors, windows, drawers, etc.	0	1	2	3	4
9.	I get upset if others change the way I have arranged things.	0	1	2	3	4
10.	I feel I have to repeat certain numbers.	0	1	2	3	4
11.	I sometimes have to wash or clean myself simply because I feel contaminated.	0	1	2	3	4
12.	I am upset by unpleasant thoughts that come into my mind against my will.	0	1	2	3	4
13.	I avoid throwing things away because I am afraid I might need them later.	0	1	2	3	4
14.	I repeatedly check gas and water taps and light switches after turning them off.	0	1	2	3	4
15.	I need things to be arranged in a particular order.	0	1	2	3	4
16.	I feel that there are good and bad numbers.	0	1	2	3	4
17.	I wash my hands more often and longer than necessary.	0	1	2	3	4
18.	I frequently get nasty thoughts and have difficulty in getting rid of them.	0	1	2	3	4

Panic Disorder Severity Scale (PDSS)

Name:_____ Date:_____

Panic Disorder Severity Scale – Self Report Form

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

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

---

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Scoring the Panic Disorder Severity Scale

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

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

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

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

PTSD Checklist for DSM-5 (PCL-5)

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

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

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

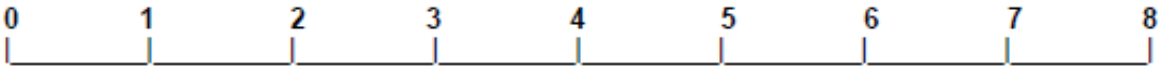
4) How often does your feature(s) **currently** lead you to avoid situations or activities?

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

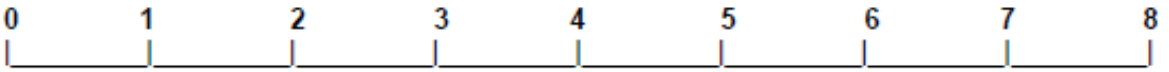
5) To what extent does your feature(s) **currently** preoccupy you? That is, you think about it a lot and it is hard to stop thinking about it?

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

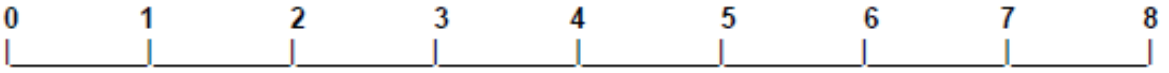
6) If you have a partner, to what extent does your feature(s) **currently** have an effect on your relationship with an existing partner? (e.g. affectionate feelings, number of arguments, enjoying activities together). If you do **not** have a partner, to what extent does your feature(s) **currently**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



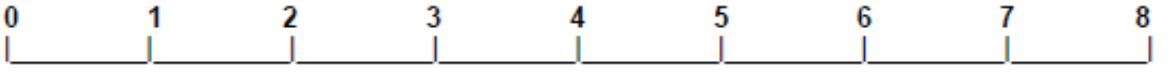
7) To what extent does your feature(s) currently interfere with your ability to work or study, or your role as a homemaker? (Please rate this even if you are not working or studying: we are interested in your ability to work or study.)



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).

Patient Health Questionnaire (Physical symptoms, PHQ-15)

PHYSICAL SYMPTOMS (PHQ-15)

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

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

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

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

Francis Irritable Bowel Scale

IBS-SSS – English

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Health Anxiety Inventory

SHORT WEEK

Ass / Wk / Sess: _____

HAI

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Never	Rarely	Sometimes	Often	Daily

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

Chalder Fatigue Questionnaire (CFQ)

chalder fatigue scale

name: _____ date: _____

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

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

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

total (0-33) =

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

Patient-reported experience measures

The assessment PEQ

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

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

Please tick one box for each question

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

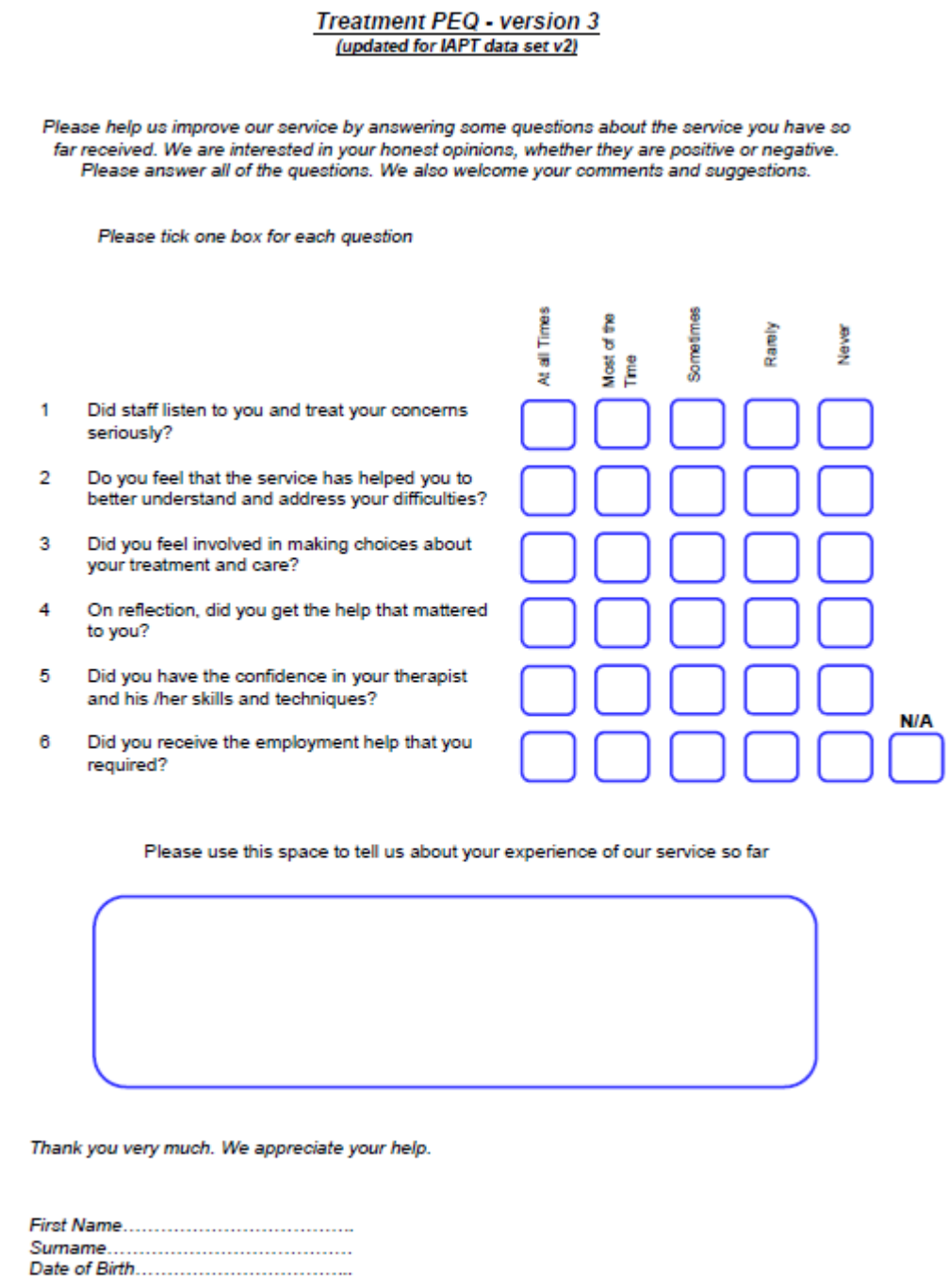
	SATISFACTION	Completely Satisfied	Mostly Satisfied	Neither Satisfied nor Dis-satisfied	Not Satisfied	Not at all Satisfied
1	How satisfied were you with your assessment?	☐	☐	☐	☐	☐

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

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

The treatment PEQ

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



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

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

Please tick one box for each question

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

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

Thank you very much. We appreciate your help.

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