

Improving Access to Psychological Therapies (IAPT)

Produced by the Corporate Research Team, Borough of Poole.



Purpose of the report

This report provides evidence, insight and understanding into the IAPT service in Poole and its users, following the IAPT aims of “ensuring that the right service is being delivered to the right people, at the right time with the right results”. Data was analysed from the IAPT outcomes dataset, relating to every IAPT service user over a 10 month period, from 1st May 2009 – 28th Feb 2010.

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Background

The Improving Access to Psychological Therapies (IAPT) programme was established by the government in 2005 to implement National Institute of Clinical Excellence (NICE) guidelines. The service enables people with anxiety and depression disorders to access NICE approved interventions and improves the collection, measurement and recording of patient’s health outcomes. To date, 112 IAPT services in three quarters of PCTs, have been or are being established¹.

The Bournemouth and Poole IAPT service was established in 2008. This report focuses on those cases within Poole.

¹ Source: Realising the Benefits: IAPT at full roll out. Department of Health, February 2010.

Key Findings

- 76% of referrals to the IAPT service were self-referrals.
- 46% were diagnosed with Anxiety Disorder.
- 31% completed treatment. Those who were unemployed or living in the most deprived quartile were more likely to have dropped out of treatment.
- Higher proportions of 20-49 year olds accessed the IAPT service than the proportions of 20-49 year olds within the population of Poole.
- MOSAIC groups N “Young people renting flats in high density social housing”, O “Families in low-rise social housing with high levels of benefit need” and I “Lower income workers in urban terraces” are over-represented in the IAPT service referrals compared to the proportions in the Poole population. These groups are the most deprived, and amongst the worst for Hospital Episodes for Depression.
- 52% were taking medication. Those aged 40-59, who had a disability, or who were unemployed were more likely to be taking medication. 26% had stopped taking medication by their last session.
- Over 70% of cases had a reduction in their depression or anxiety scale scores by their last session. Just over 60% had a reduction in their work and social adjustment scale score.
- 7% of those were unemployed at their first session, were back in employment by their last session.

The National Picture

In 2007², nearly 1 in 4 (23%) adults in England had at least 1 psychiatric disorder and 7% had 2 or more disorders. Just over 1.1 million adults in England accessed NHS Specialist Mental Health Services in 2008/2009 (around 3% of the adult population)³.

Common Mental Disorders (CMD) include various types of anxiety and depression that cause a degree of emotional distress and interfere with daily function. The 2007 Adult Psychiatric Morbidity Survey found that, among private households, 16% of adults met the criteria for at least 1 common mental health problem, with more than half (9%) having Mixed Anxiety and Depression.

Women (20%) were more likely to have a CMD than men (13%) and rates of CMD also varied by age. In women, 45-54 year olds had this highest rate, with a quarter (25%) meeting the criteria for at least 1 CMD. In males, the rate was highest among 25-54 year olds with 15% meeting the criteria for at least 1 CMD. Rates were lowest among those aged 75 and over (12% women 75+, 6% males 75+).

Mental Health in Poole

In the period 2008/2009, just over 3400 adults in Poole accessed NHS Specialist Mental Health Services (around 3% of the adult population in Poole).

Table 1 below shows predicted numbers of the population in Poole expected to have a common mental health problem. Rates of all common disorders are not predicted to change to a great extent to 2030, with a very small decrease.

Females are predicted to have a higher incidence than males for common mental disorders – with 58% of cases in 2009 predicted to be female, and 35% male, following the national trend.

² Source: Adult Psychiatric Morbidity Survey, 2007. NHS Information Centre

³ Source: Adults accessing NHS Specialist Mental Health Services 2008/2009. Neighbourhood Statistics.

Table 1: Poole population aged 18-64 predicted to have a common mental health problem, projected to 2030

		2009	2015	2020	2025	2030
Males (18-64)	Common Mental Disorder	4,913	4,788	4,750	4,750	4,725
	Borderline Personality Disorder	118	115	114	114	113
	Anti-Social Personality Disorder	236	230	228	228	227
	Psychotic Disorder	118	115	114	114	113
Females (18-64)	Common Mental Disorder	8,018	7,821	7,762	7,663	7,585
	Borderline Personality Disorder	244	238	236	233	231
	Anti-Social Personality Disorder	41	40	39	39	39
	Psychotic Disorder	204	199	197	195	193
<i>Total</i>		<i>13,892</i>	<i>13,546</i>	<i>13,440</i>	<i>13,336</i>	<i>13,226</i>

Source: PANSI 3.0, Based on Adult Psychiatric Morbidity in England, 2007

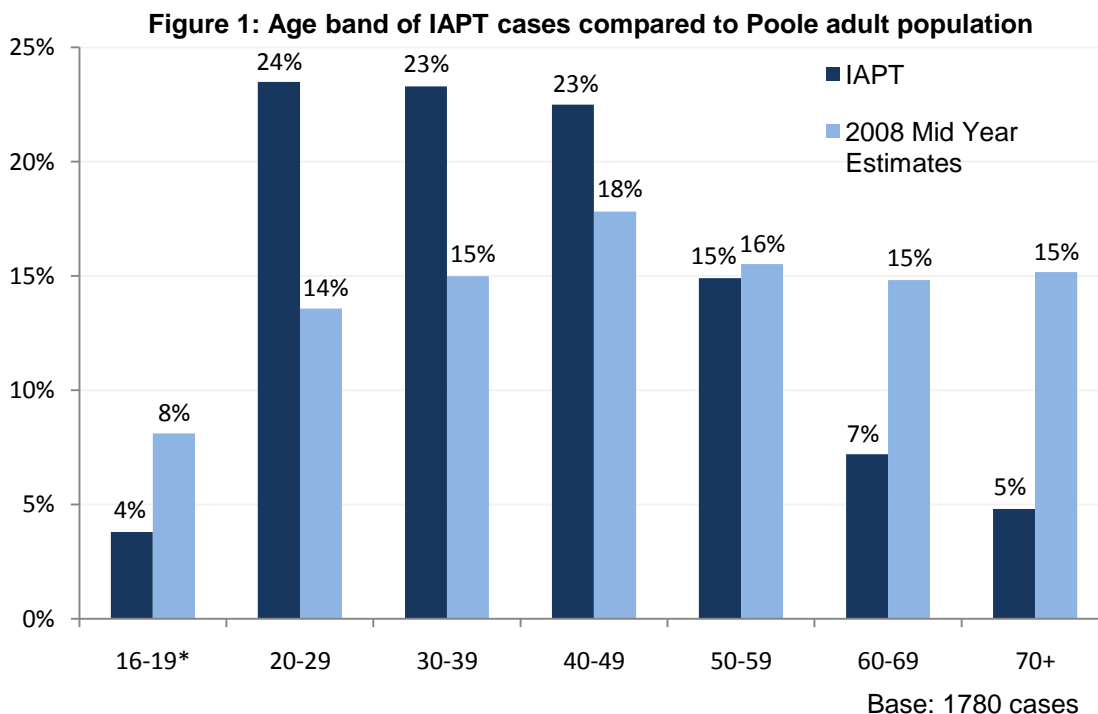
Analysis

Data is analysed by a person’s first contact with the IAPT service. Those cases at postcodes not within the Poole boundary are excluded. There were 1780 unique contacts with the IAPT service between May 2009 and February 2010.

Demographics

Age

4% of people who made contact with the IAPT service were aged 16-19. 69% were aged between 20 and 49 and 27% were aged over 50. Figure 1 below shows a breakdown of cases by broad age band.



*2008 mid-year estimates are for the age range 15-19

Among the Poole adult population (15+ years) 8% are aged 15-19 years, 45% 20-49 years and 48% are aged over 50 (ONS 2008 mid-year estimate).

Gender

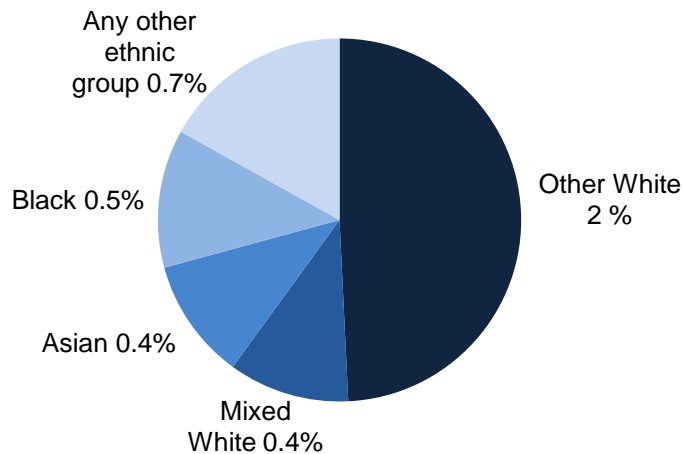
37% of people who contacted the IAPT service were male and 63% were female.

The Adult Psychiatric Morbidity survey found that, nationally, women were more likely to have a common mental health disorder than men⁴.

Ethnicity

96% of IAPT cases were White British with the remaining 4% belonging to Black and Minority Ethnic Groups (BME) (Ethnicity information was known for 1609 cases). This reflects the proportions of the population of Poole. Figure 2 shows a breakdown of ethnicity for BME cases (65 cases).

Figure 2: BME group of IAPT cases other than White British



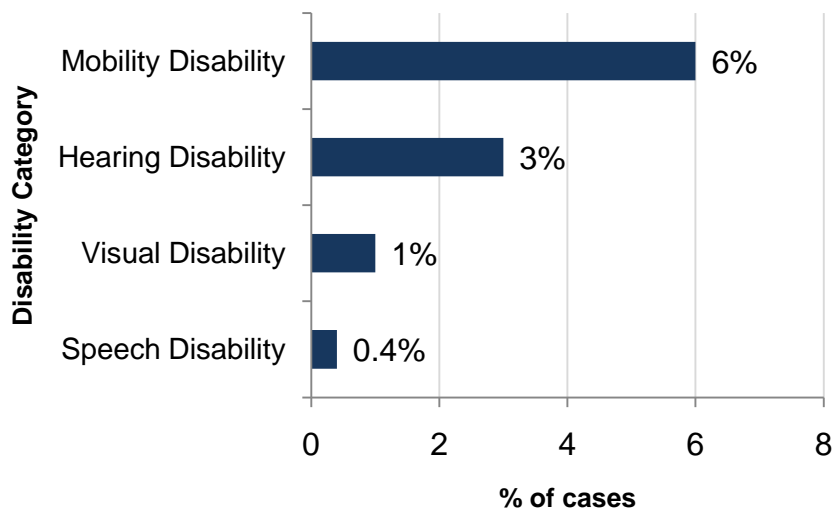
Base: 65 cases

Disability

9% of IAPT cases had a disability – Figure 3 shows a breakdown of disability types for these cases (some cases have more than 1 disability type).

In the 2001 census, 18.5% of the Poole population stated that they had a limiting long-term illness (any long-term illness, health problem or disability that limits daily activities or work). In 2009, 5600 residents were claiming Disability Living Allowance (4% of the population) (Neighbourhood Statistics).

Figure 3: Disability category for IAPT cases with a disability



⁴ Adult Psychiatric Morbidity Survey, 2007. NHS Information Centre

Religion

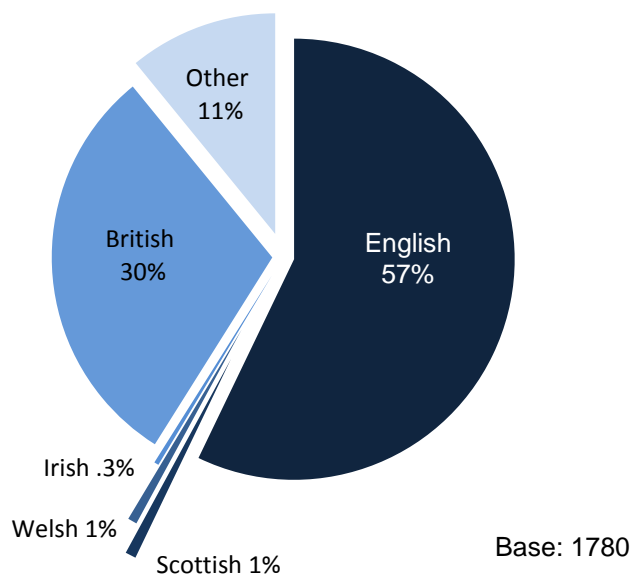
Religion data was collected for 1582 IAPT cases. 63% of cases have no religious group or are Atheist/Agnostic. Of those cases belonging to a religious group, 34% were Christian, 0.4% Jewish, 0.3% Muslim and 2.4% Any Other Religion.

In the 2001 census, 16% of Poole residents stated that they had no religion, and 74% were Christian.

National Identity

National Identity was known for 1780 cases. Of these, 57% identified as English, and 30% as British. The chart below shows the breakdown for all cases.

Figure 4: National Identity of IAPT cases



Language

99.6% of cases could understand spoken English, and 99.4% could understand written English. Preferred language information was known for 1780 cases. 99.7% stated that English was their preferred language. Other languages preferred included Dutch, Italian and Portuguese.

Sexual Orientation

Information on Sexual Orientation was known for 1609 cases, of which 97% stated that they were heterosexual, 2% were lesbian or gay, and 1% were bisexual.

MOSAIC

MOSAIC is a public sector citizen classification system produced by Experian. It classifies residents into 15 groups in which there are 69 household types. Each group and type has a detailed profile of various demographic and socio-economic information.

MOSAIC Groups

The largest proportion of IAPT cases belong to MOSAIC group H “Couples and young singles in small modern starter homes” (15%). Residents in group H are likely to have been born and brought up locally and to have recently moved out of their parents’ home to set up on their own or with a partner. Financial stress and binge drinking are two common causes of ill health for this group. This group is ranked 3rd of all the MOSAIC groups for Hospital Episode Statistics (HES) for Depression⁵ (where 1 is worst and 15 is best).

⁵ Hospital Episode Statistics looks at all admissions to NHS hospitals in England for Depression.

Table 2: Ranked proportions of IAPT cases in each MOSAIC group, compared to the proportion of adults in Poole.

Rank	Group	Description	% of IAPT cases	% of adults 18+ in Poole	Index
1	H	Couples and young singles in small modern starter homes	15	9	163
2	B	Residents of small and mid-sized towns with strong local roots	13	16	80
3	E	Middle income families living in moderate suburban semis	12	12	103
4	J	Owner occupiers in older-style housing in ex-industrial areas	11	10	116
5	K	Residents with sufficient incomes in right-to-buy social housing	10	7	145
6	D	Successful professionals living in suburban or semi-rural homes	9	14	64
7	L	Active elderly people living in pleasant retirement locations	9	13	69
8	M	Elderly people reliant on state support	5	5	94
9	I	Lower income workers in urban terraces in often diverse areas	4	2	168
10	F	Couples with young children in comfortable modern housing	4	4	95
11	O	Families in low-rise social housing with high levels of benefit need	3	2	178
12	G	Young, well-educated city dwellers	3	2	132
13	C	Wealthy people living in the most sought after neighbourhoods	2	4	54
14	N	Young people renting flats in high density social housing	1	<0.5	206
15	A	Residents of isolated rural communities	<0.5	<0.5	67

In Table 2, those groups with an Index score over 100 are over-represented in contacts with the IAPT service (the proportion of the group within the IAPT cases is higher than the proportion of that group among households in Poole). This is expected given the profile of these MOSAIC groups and that some groups are more vulnerable to mental health issues than others.

MOSAIC Group N has an index of 206, and is double that of the proportion of adults in Poole. Group N residents “Young people renting flats in high density social housing” are people on limited incomes mostly renting small flats from local councils or housing associations, typically young single people or young adults sharing a flat. This group is ranked 2nd of all 15 groups in terms of deprivation (where 1 is most deprived and 15 least deprived) and worst for HES for Depression.

Group O “Families in low-rise social housing with high levels of benefit need” has an index of 178. This group is ranked the most deprived of all the MOSAIC groups and 4th for HES for Depression. Within this group lack of family and community support, low income and unemployment can result in serious levels of social stress and demands for social services.

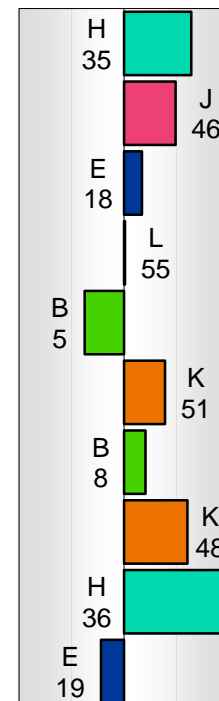
Group I “Lower income workers in urban terraces in often diverse areas” has an index of 168. This group is ranked 3rd for deprivation and 5th for HES for Depression. Group I residents have poor qualifications and work in menial, routine occupations. The majority are young people, often coming from overseas. The group is vulnerable to a number of health conditions.

Mosaic Types

Each MOSAIC group can be split into several MOSAIC types. MOSAIC types provide detailed demographic and socio-economic information of the people who make up a MOSAIC group. For example, Group H “Couple and Young singles in modern starter homes” can be further divided into 4 types; H35 “Childless New Owner Occupiers”, H36 “Young singles and Sharers”, H37 “Young owners and rented developments” and H38 “People living in brand new residential developments”. Table 3 shows the top 10 MOSAIC types among IAPT cases.

Table 3: Ranked proportions of MOSAIC types among IAPT cases, compared to proportions of adults in Poole.

Rank	Type	Description	% of IAPT cases	% of adults 18+ in Poole	Index
1	H35	Childless new owner occupiers in cramped new homes	9	6	164
2	J46	Residents in blue collar communities revitalised by commuters	7	4	149
3	E18	Industrial workers living comfortably in owner occupied semis	5	4	117
4	L55	Capable older people leasing / owning flats in purpose built blocks	5	5	101
5	B5	Better off empty nesters in low density estates on town fringes	4	7	63
6	K51	Often indebted families living in low rise estates	4	3	139
7	B8	Mixed communities with many single people in the centres of small towns	4	3	120
8	K48	Middle aged couples and families in right-to-buy homes	4	2	160
9	H36	Young singles and sharers renting small purpose built flats	3	2	200
10	E19	Self reliant older families in suburban semis in industrial towns	3	4	78



The top 3 MOSAIC types accessing the IAPT service are H35 (9%), J46 (7%) and E18 (5%).

Type H35 are young couples on middle incomes who have recently bought a new house on a private estate. Typically they will be paying a substantial proportion of their monthly income on mortgage interest. They are ranked 20 out of 69 (where 1 is the worst) for HES for Depression, and ranked 43 of 69 for deprivation.

Type J46 contains many people in their early 30's with one or more children. Levels of need for adult social services are modest, and health conditions are improving. This type is ranked 47 of 69 for deprivation, and 34 of 69 for HES due to depression.

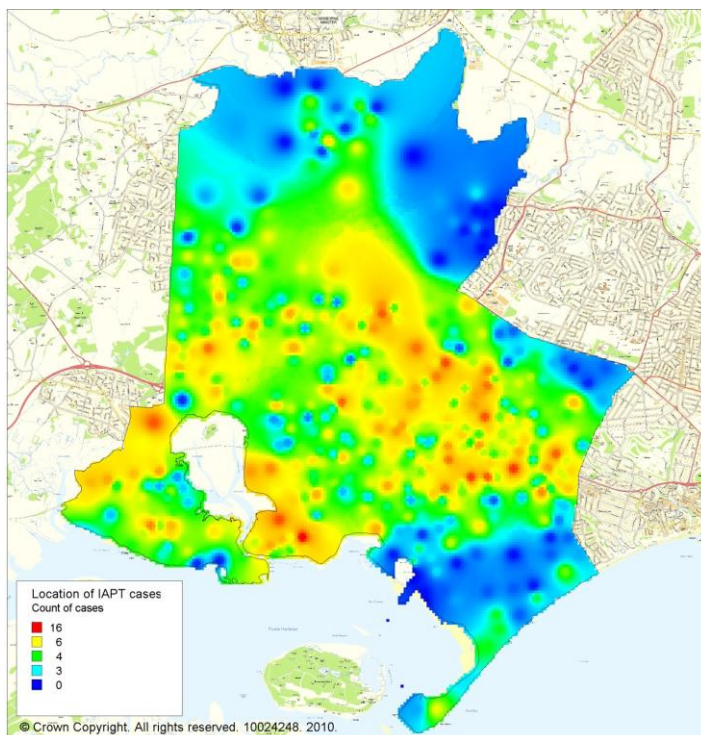
Type E18 tend to contain families headed by junior white-collar or semi-skilled manual workers, few with a high level of education. During recessionary times these residents are particularly vulnerable to redundancy. This type is ranked 52 of 69 for deprivation and 38 of 69 for HES due to Depression.

Due to the impact of the recession and the future economic situation, these types may have an increasing need for access to mental health services.

Location

Figure 5 below shows the distribution of IAPT cases across the Borough⁶.

Figure 5: Hotspots of people accessing the IAPT service



The largest hotspot of cases accessing the IAPT service is located in Poole Town. Other hotspots of people accessing the service are located in Turlin Moor, Parkstone, Rossmore and Canford Heath. There are fewer cases from the Broadstone, Merley and Bearwood areas, plus Canford Cliffs and Branksome.

Figure 6: Location of MOSAIC groups with highest rates of Depression

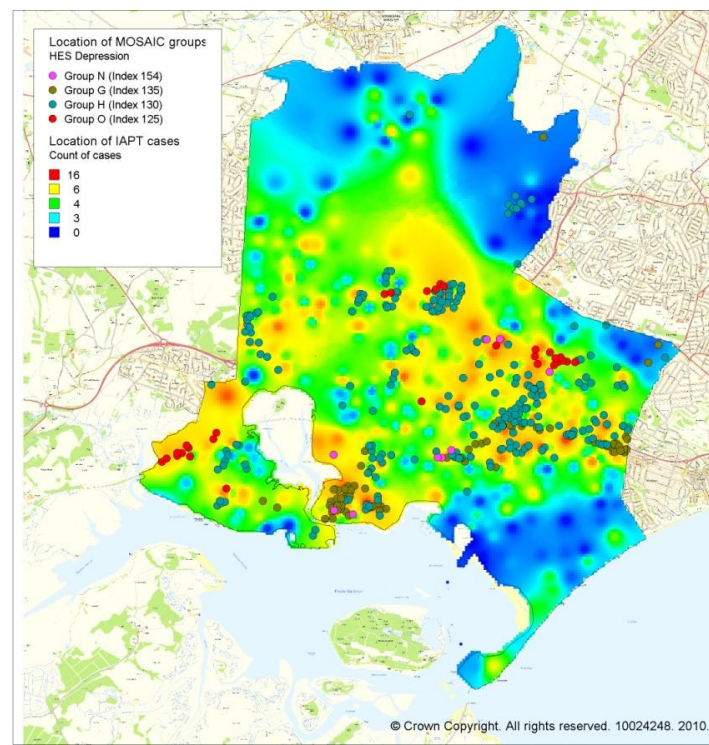


Figure 6 shows the location of those MOSAIC groups who have the highest incidence of Hospital Episodes due to Depression. The location of the groups follows the distribution of IAPT cases,

⁶ This shows high or low concentrations of people accessing the IAPT service, and does not necessarily reflect the incidence of common mental health disorders.

although there is a cluster of Group H “Couples and young singles in small modern starter homes” located in Bearwood. The group most at risk is Group N “Young people renting flats in high density social housing” with an index of 154, followed by Group G “Young well-educated city dwellers” with an index of 135.

Figure 7: Location of most deprived MOSAIC groups

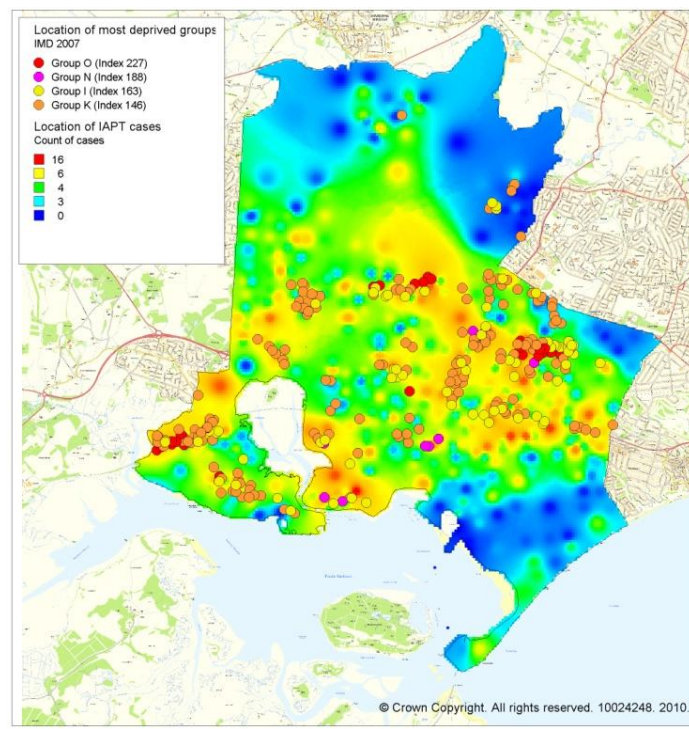


Figure 7 shows the distribution of the most deprived MOSAIC groups. Again, the distribution fits that of IAPT cases, although there is a small cluster of Group I and Group K in Bearwood. The most deprived MOSAIC group is Group O “Families in low-rise social housing with high levels of benefit need” (Index 227).

Figure 8: Location of most elderly MOSAIC groups

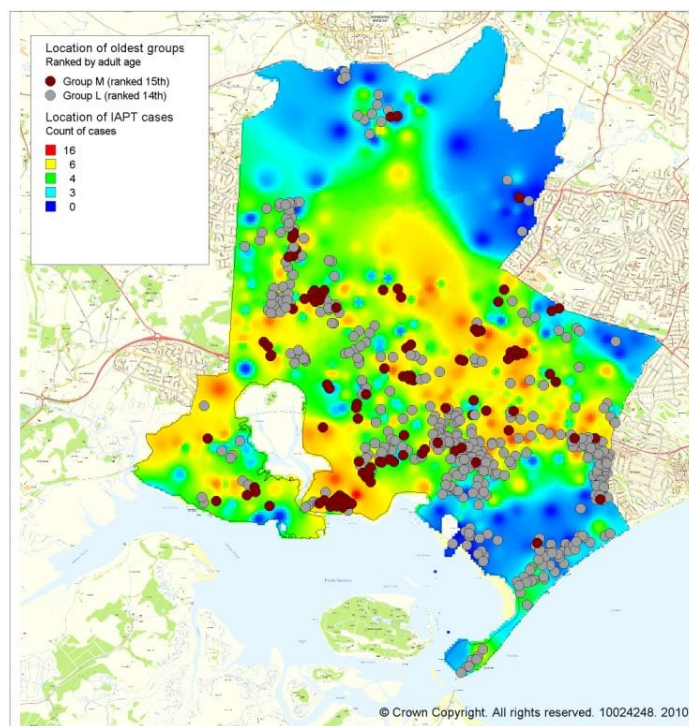


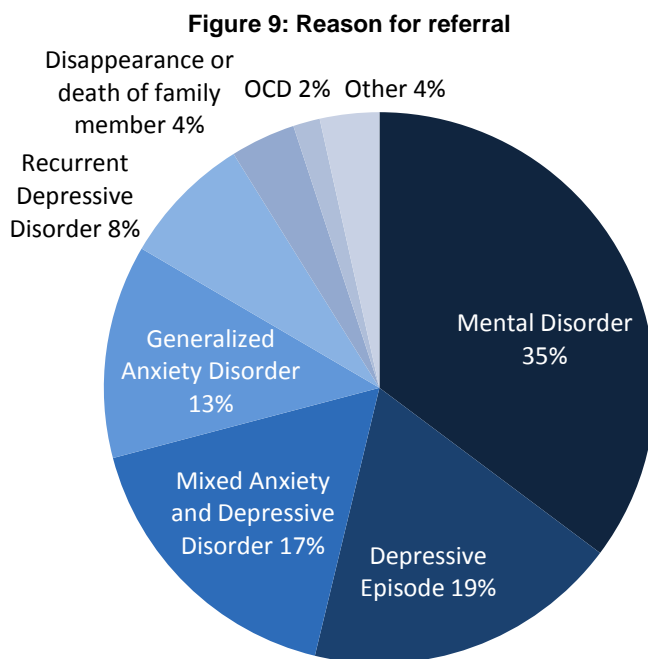
Figure 8 shows the location of the most elderly MOSAIC groups. Group M are “Elderly people reliant on state support” and Group L “Active elderly people living in pleasant retirement locations”. There are clusters of these groups in Broadstone, Merley, Poole Old Town, Parkstone, Lilliput,

Canford Cliffs and Branksome. These locations have fewer IAPT cases accessing the service. Group M 'poor elderly' are located more centrally and in some of the more deprived areas than Group L.

The IAPT Service

Referrals

97% of referrals to the IAPT service were accepted. 76% of referrals were self-referrals, 16% from GP's and 5% from other clinical specialities. The remaining 3% included referrals from Social Services, Community/Practice nurses and Health Visitors. Figure 9 shows the proportions of referred problems⁷ to the IAPT service.

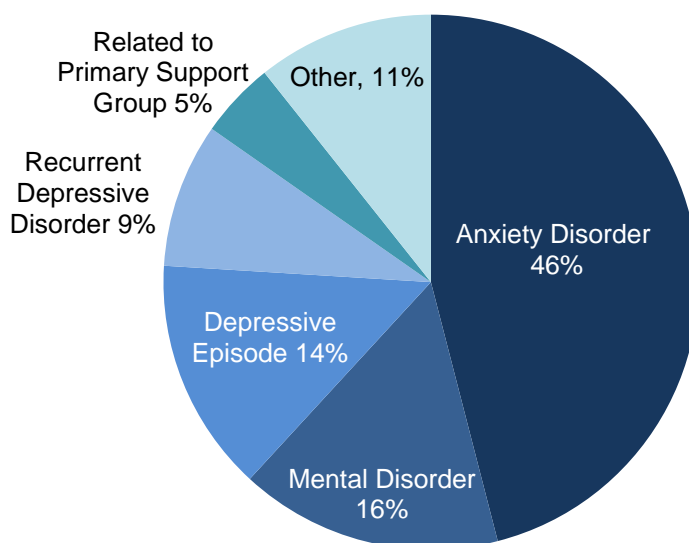


Base: 1780

Primary Diagnosis

A primary diagnosis was available for 870 cases. Figure 10 shows the prevalence of disorders according to primary diagnosis.

Figure 10: Primary diagnosis of IAPT cases



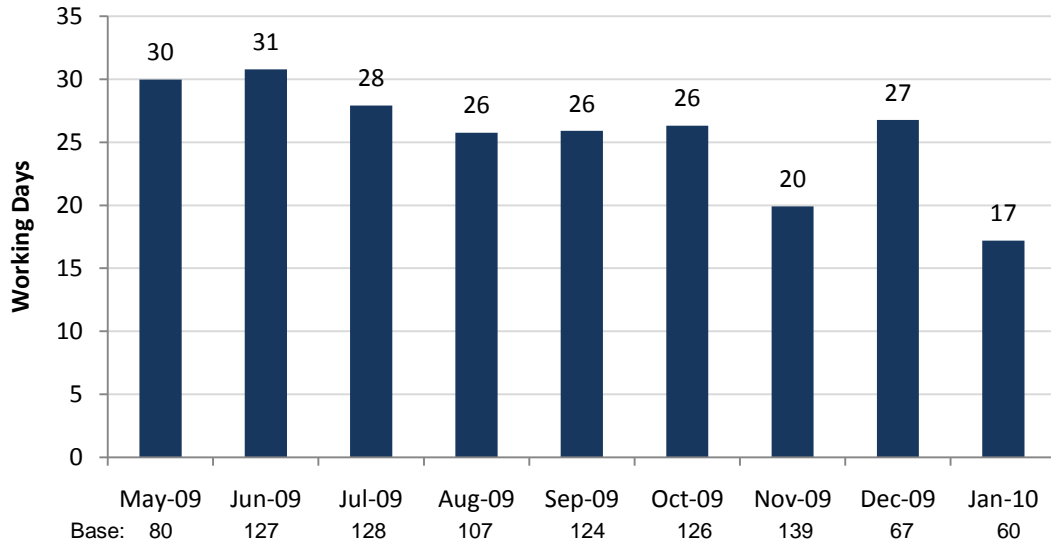
'Other' also includes Agoraphobia, OCD and Reaction to Severe Stress

⁷ Diagnosis Definitions are available in Appendix A

Date of first session

The date of first session was available for 968 cases. The mean working day difference between the date the referral was received and the date of the first session was 26 working days. Figure 11 shows the average working day difference across time (February data is not included due to small numbers).

Figure 11: Average time between referral and first session



End of Care Pathway

The date of end of care for those who had completed treatment was available for 389 cases. The mean working day difference between the date the referral was received and the end of care pathway was 63 working days. Figure 12 shows the average working day difference across time (December - February data is not included due to small numbers).

Figure 12: Average time within the IAPT service

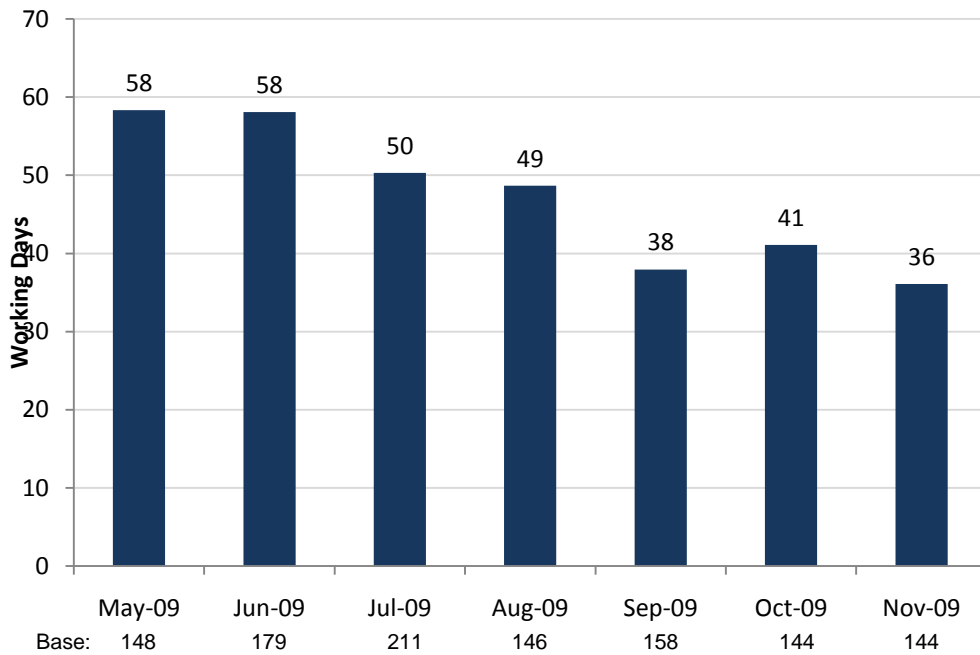


Table 4 shows the reason for the end of the care pathway (known for 1241 cases).

Table 4: Reason for the end of care

	Count	% of IAPT cases
Completed Treatment	389	31
Declined Treatment	488	39
Dropped out of treatment	182	15
Not suitable for service	182	15
Total	1241	100

Significant differences in completing treatment

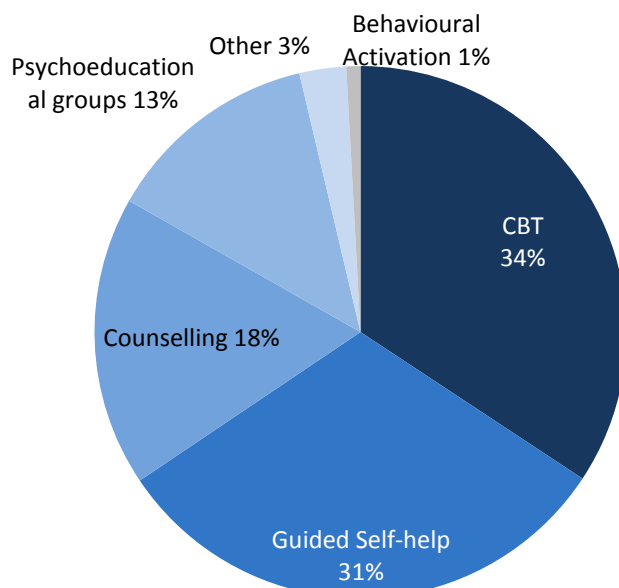
Age
 Cases aged 40-49 years and 70+ years were more likely than other age groups to have completed treatment (37% of 40-49 years & 42% of 70+ completed treatment). Those cases aged 16-19 and 20-29 were more likely to have declined treatment than other ages (53% 16-19 & 46% 20-29 years declined treatment). Cases aged 70+ were more likely to not be suitable for the service (27% were not suitable).

Employment Status
 Those cases that were unemployed at their first session were more likely to have dropped out of treatment than other cases (33% dropped out of treatment).

Indices of Multiple Deprivation
 Those cases residing in the most deprived quartile (Q1 - based on Indices of Multiple Deprivation) were more likely to have dropped out of treatment than other quartiles (23% dropped out of treatment). Those cases from the least deprived quartile (Q4) were more likely to have completed treatment (37% completed treatment).

Type of therapy (intervention) given
 Data on the type of intervention given (for completed cases) was available for 703 cases. 34% of cases were receiving Cognitive Behavioural Therapy (CBT) at their last session, and 31% were receiving Guided Self-help.

Figure 13: Type of treatment



Medication Usage

Use of medication at first session was known for 1124 cases, of which 52% were taking medication. Of these, 75% were taking Selective Serotonin Reuptake Inhibitor (SSRI) antidepressants.

Table 5: Type of medication used

Type	Count	Percent
SSRI anti-depressant	345	75
TriCyclic anti-depressant	37	8
Other anti-depressant	35	8
Beta-blocker	11	2
Hypnotic or Anxiolytic	11	2
Other Psychotropic Medication	23	5
Total	462	100

Information on medication use at last session was available for 369 cases. At this stage, 26% (96) cases had stopped taking medication.

Significant Differences – Medication Use

Age

Cases aged 40-49 and 50-59 years were more likely to be taking medication than other age groups (60% of 40-49 & 60% 50-59 years were taking medication at their first IAPT session). Cases aged 20-29 were more likely to not be taking any medication (57% not taking medication at first session).

Disability

Cases who had a disability were more likely to be taking medication at their first session than non-disabled cases (62% cases with a disability were taking medication).

Employment Status

Those cases that were unemployed at their first session were more likely to be taking medication than other cases (62% were taking medication at their first session). Cases who were employed full-time were more likely not to be taking medication (52% were not taking medication at their first session).

Outcome Measurement Scales

Outcome measurement scores are collected on a session by session basis. This means that, for those patients who may drop out or terminate their therapy, a clinical endpoint is available. Therefore, the tables below show data for all cases where a last session score was recorded. Details on all of the scales below can be found in Appendix B.

Patient Health Questionnaire for Depression (PHQ9)

The PHQ9 is a tool to determine a provisional depressive disorder diagnosis, and also measures disorder severity. It asks patients to rate how often they have been bothered by 9 specific problems in the last 2 weeks. The 9 problems directly relate to criteria on which the diagnosis of DSM-IV depressive disorders is based. The maximum score for this scale is 27, with a score of 10 or more indicating a moderate to severe depressive disorder.

Table 6: PHQ9 percentage score reductions for all cases, and those with moderate to severe depression.

% reduction in score	All cases		Cases with a first score of 10+	
	Count	Percent	Count	Percent
Less than 10%	39	7%	39	9%
10% - 29%	123	22%	104	24%
30% - 49%	103	19%	86	20%
50% - 69%	128	23%	93	21%
70% - 89%	91	17%	77	18%
90% or more	63	12%	39	9%
Total	547	100%	438	100%

Complete scale scores were available for 719 cases. Of these, 76% had some reduction in their PHQ9 score at their last session. Table 6 shows the amount of reduction in PHQ9 score for all cases, and those with a first score of 10 or more.

For all cases, 51% had a reduction of 50% or more in their scale score by their last session. 48% of those with moderate to severe depressive disorder had a reduction of 50% or more.

Patient Health Questionnaire for Anxiety (GAD7)

The GAD7 is a tool to determine a Generalized Anxiety Disorder Diagnosis, and also measures disorder severity. Patients rate how often that they have been bothered by 7 specific problems in the last 2 weeks. The maximum score for this scale is 21, with a score of 10 or more indicating a moderate to severe anxiety disorder.

Table 7: GAD7 percentage score reductions for all cases, and those with moderate to severe anxiety

% reduction in score	All cases		Cases with a first score of ??	
	Count	Percent	Count	Percent
Less than 10%	26	5%	26	7%
10% - 29%	118	23%	87	22%
30% - 49%	98	19%	76	19%
50% - 69%	123	24%	92	23%
70% - 89%	108	21%	85	21%
90% or more	47	9%	32	8%
Total	520	100%	398	100%

Complete scale scores were available for 719 cases. Of these, 72% had some reduction in their GAD7 score. Table 7 shows the amount of reduction in GAD7 score for all cases, and those with a first score of 10 or more.

For all cases, 53% had a reduction of 50% or more in their scale score by their last session. 53% of those diagnosed with a moderate to severe anxiety disorder had a score reduction of 50% or more.

Work and Social Adjustment Scale (W&SAS)

The W&SAS scale measures a patient's perspective of their level of impairment in 5 areas – work, home management, social leisure activities, private leisure activities and Family & relationships. The maximum score for this scale is 40, with a score of 20 or more indicating moderate to severe impairment in these functions.

Table 8: W&SAS percentage score reductions for all cases, and those with moderate to severe impairment

% reduction in score	All cases		Cases with a first score of 20+	
	Count	Percent	Count	Percent
Less than 10%	36	7%	22	9%
10% - 29%	108	22%	67	26%
30% - 49%	99	20%	61	24%
50% - 69%	105	21%	51	20%
70% - 89%	80	16%	38	15%
90% or more	67	14%	18	7%
Total	495	100%	257	100%

Complete scale scores were available for 719 cases. Of these, 69% had some reduction in their W&SAS score. Table 8 shows the amount of reduction in W&SAS score for all cases, and those with a first score of 20 or more.

For all cases, 51% had a reduction of 50% or more in their scale score by their last session. 42% of those diagnosed with a moderate to impairment had a score reduction of 50% or more.

Phobia Scales

These consist of three single item scales covering the main clinical phobias. Ranking severity on a scale of 0 to 8 gives an indication of the presence of a phobic condition. Table 9 shows the amount of reduction in scale score for all cases, for the three phobia related questions.

Question 1 – Social phobia

Question 2 – Panic Disorder/ Agoraphobia

Question 3 – Specific Phobia

Complete scale scores were available for 719 cases. 51% had a reduction for Phobia Q1, 45% had a reduction for Phobia Q2 and 41% had a reduction for Phobia Q3.

Table 9: Phobia percentage scale score reductions for all cases

% reduction in score	Phobia Q1		Phobia Q2		Phobia Q3	
	Count	Percent	Count	Percent	Count	Percent
Less than 10%	0	0%	0	0%	0	0%
10% - 29%	43	12%	43	13%	41	14%
30% - 49%	65	18%	41	13%	37	13%
50% - 69%	103	28%	70	22%	73	25%
70% - 89%	35	10%	27	8%	27	9%
90% or more	118	32%	143	44%	116	39%
Total	364	100%	324	100%	294	100%

Employment Status

Employment information at first appointment was known for 1133 cases. Of these, 55% were employed, either full-time or part-time and 22% were unemployed. 8% of cases were receiving Statutory Sick Pay (SSP) at the first appointment, and 26% were in receipt of benefits (includes Job Seekers Allowance, Incapacity Benefit and Income Support).

Table 10: Employment status at first session

Employment Status	Count	% of IAPT cases
Employed full-time	415	37
Employed part-time	202	18
Unemployed	244	22
Full-time Student	17	2
Retired	129	11
Full-time homemaker or carer	126	11
Total	1133	100

Of the 244 cases who were unemployed at their first session, employment information at last session was known for 153. Of these, 7% (11 cases) were employed (either full or part-time) at their last session, but 79% (121 cases) were still unemployed.

Of the 290 cases receiving benefits at their first session, information on benefits at their last session was available for 175 cases. 20% (35 cases) were no longer receiving benefits at their last session.

Information on receiving SSP at last contact was known for 62 cases who had been receiving SSP at their first session. 58% (36 cases) were no longer receiving SSP at their last session.

Appendix A – Diagnosis Definitions

Generalized anxiety disorder

Anxiety that is generalized and persistent but not restricted to, or even strongly predominating in, any particular environmental circumstances (i.e. it is “free-floating”). The dominant symptoms are variable but include complaints of persistent nervousness, trembling, muscular tensions, sweating, light-headedness, palpitations, dizziness, and epigastric discomfort. Fears that the patient or a relative will shortly become ill or have an accident are often expressed.

Depressive episode

The patient suffers from lowering of mood, reduction of energy and decrease in activity. Capacity for enjoyment, interest and concentration is reduced, and marked tiredness after even minimum effort is common. Sleep is usually disturbed and appetite diminished. Self-esteem and self-confidence are almost always reduced and even in the mild form some ideas of guilt and worthlessness are often present. The lowered mood varies little from day to day, is unresponsive to circumstances and may be accompanied by so-called “somatic” symptoms.

Recurrent depressive disorder

A disorder characterized by repeated episodes of depression as described for depressive episode without any history of independent episodes of mood elevation and increased energy.

Mixed anxiety and depressive disorder

Symptoms of anxiety and depression are both present, but neither is clearly predominant, and neither type of symptom is present to the extent that justifies a diagnosis if considered separately.

Obsessive-compulsive disorder

Recurrent obsessional thoughts or compulsive acts. Obsessional thoughts are ideas, images or impulses that enter the patient’s mind again and again in a stereotyped form. They are almost invariably distressing and the patient often tries, unsuccessfully, to resist them. Compulsive acts or rituals are stereotyped behaviours that are repeated again and again. Anxiety is almost invariably present – if compulsive acts are resisted the anxiety gets worse.

Disappearance and death of a family member

Assumed death of family member

Mental disorder, not otherwise specified

Mental illness not otherwise specified

(Source: World Health Organisation International Classification of diseases (ICD-10)
<http://www.who.int/classifications/icd/en/>)

Appendix B – Outcome Measurement Scales

Patient Health Questionnaire for Depression (PHQ9)

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
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Patient Health Questionnaire for Anxiety (GAD7)

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
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

Work and Social Adjustment Scale (W&SAS)

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems look at each section and determine on the scale provided how much your problem impairs your ability to carry out the activity. (Scale is 0 to 8 where 0 is Not at all, and 8 is very severely).

1. Work – if you are retired or choose not to have a job for reasons unrelated to your problem please tick N/A.
2. Home Management – Cleaning, tidying, shopping, cooking, looking after home/children, paying bills e.t.c.
3. Social Leisure Activities – with other people e.g. parties, pubs, outings, entertaining e.t.c.
4. Private Leisure Activities – Done alone e.g. reading, gardening, sewing, hobbies, walking e.t.c.
5. Family and Relationships – form and maintain close relationships with others including the people that I live with.

Phobia Scales

Choose a number from the scale below to show how much you would avoid each of the situations or objects listed below. (Scale is from 0 = would not avoid it to 8 = Always avoid it)

Question 1

Social situations due to a fear of being embarrassed or making a fool of myself.

Question 2

Certain situations because of a fear of having a panic attack or other distressing symptoms (such as a loss of bladder control, vomiting or dizziness).

Question 3

Certain situations because of a fear of particular objects or activities (such as animals, heights, seeing blood, being in confined spaces, driving or flying).

(Source: IAPT Outcomes Toolkit 2008/09

http://www.eoe.nhs.uk/downloadFile.php?doc_url=1221651422_blad_iapt_outcomes_toolkit_2008_.pdf)