

Evaluation of Transactional Analysis Psychotherapy Groups In Primary Care Within and Existing IAPT site

Introduction

Therapeutic groups have been used in psychological treatments for decades. They encompass a wide variety of structures and approaches. Groups have been used to raise awareness, develop skills and deal with psychological distress. Because of their versatility and cost effectiveness they represent a potentially important resource in increasing access to psychological therapies. However, this abundance of possibilities raises questions about types of groups that would be the most effective within the context of primary care in an urban area with a high degree of diversity and deprivation.

Literature

There are a number of research studies into the uses of group psychotherapy and counselling in both health and educational settings. Group treatments are rooted in the rich tradition of therapeutic theory and practice and used in a variety of settings for prevention, personal development and education, counselling and psychotherapy. They span psychoanalytic, cognitive-behavioural and humanistic theoretical orientations.

Barlow (2008) defines the group psychotherapy as mental health treatment based in social psychological research on group dynamics. Evaluation of group psychotherapy shows that it is an effective treatment for different client groups. Burlingame (Burlingame, Fuhrman, & Mosier, 2003) evaluated a differential effectiveness of group psychotherapy in a meta-analysis of 111 experimental and quasi-experimental studies published over the past 20 years. A number of client, therapist, group, and methodological variables were examined in an attempt to determine specific as well as generic effectiveness. The outcome showed that the average recipient of group treatment was better off than 72% of untreated controls. Improvement was related to group composition, setting, and diagnosis.

Evidence shows that group psychotherapy is effective with different client groups : clients suffering from anxiety and depression,(Chen, Lu, Chang, Chu, & Chou, 2006; Dodding, Nasel, Murphy, & Howell, 2008), HIV infected clients (Himelhoch, Medoff, & Oyeniy, 2007), adults who have experienced childhood sexual abuse(Lau & Kristensen, 2007), girls (age 9-15) who attend school for children with complex needs (Flitton, Buckroyd, & Vassiliou, 2006) and others.

Current body of research doesn't fully represent a range of theoretical approaches currently used in group therapy. Transactional Analysis (TA) is a theoretical approach developed from an integration of cognitive and psychodynamic principles within the humanistic philosophical framework, by Erik Berne in the late 1950's. TA focused on group therapy from its inception, and maintained group work in training and certification of psychotherapists. Some evaluative studies of Transactional Analysis groupwork are available within psychiatric settings (Thunnissen, Duivenvoorden, & Trijsburg, 2002) and therapeutic communities working with addiction.(Ohlsson, 2002). The structure and flexibility of this approach, and its emphasis on client empowerment, make it a potentially useful tool for working with the diverse patient populations within primary care.

Even though evaluation of group treatments demonstrates their effectiveness, the comparison between individual and group treatments shows that although

there are no differences between theoretical approaches such as counselling and cognitive behavioural therapy, the individual approaches may be more effective (Milgrom, Negri, Gemmill, McNeil, & Martin, 2005). However, this could be related to issues such as patient choice (Ryan, Nitsun, Gilbert, & Mason, 2005) and personal history (Piper, Ogrodniczuk, Joyce, Weideman, & Rosie, 2007) and further research is needed into developing the most effective group treatments for different contexts.

Research Aims

This study aims to evaluate the effectiveness of Transactional Analysis psychotherapy group treatment within the existing primary care service, engaged in provision of a range of psychological treatments and evaluation as one of the IAPT sites (CSIP, 2008, Appendix 1).

The project is a naturalistic study and the collaboration between Metanoia Institute and Sutton and Merton Psychological Services in Primary Care (PTiPC). The project will take place between September 2010 and July 2011.

Group Intervention

Groups be time limited (16 sessions) and facilitated by Transactional Analysis psychotherapists, who are students at Metanoia Institute on placement within PTiPC. Psychotherapists' adherence to the theoretical approach will be measured using Adherence questionnaires devised by Metanoia Institute.

Research Design

The study will take place within the IAPT project (CSIP, 2008) and will use the existing evaluation methods and systems and patient inclusion and exclusion criteria. (Appendix 1)

Transactional Analysis Psychotherapists – practitioners will be senior TA psychotherapy students at Metanoia Institute. During the project they will facilitate up to four groups per week

Adherence to the theoretical approaches – The Transactional Analysis theoretical approach will be applied using the core skills, theoretical knowledge and attitudes defined in the Handbooks for the Transactional Analysis psychotherapy training at Metanoia Institute. The courses at Metanoia Institute have been validated by Middlesex University and accredited by the national umbrella bodies – UKCP, BACP and BPS.

All sessions will be audio-recorded. Clinical supervisor will offer monthly clinical supervision to the psychotherapist and the assistant. S/he will listen to these recordings and assess after every four sessions whether the approach used matched the theoretical approach, as defined by the course Handbooks.

Measures

- Metanoia students on placement with PTiPC will continue to collect the minimum data set including PHQ9 and GAD7 at every session.
- The data that students collect and enter onto the data base system, IAPTus will be made available to Metanoia for use in a research project on the 'effectiveness of Transactional Analysis'.

- In order to assess the working alliance in each group the patients will be asked to complete the Working Alliance Inventory (WAI) post each group session.
- Adherence questionnaires will be completed every four sessions

Research Analysis

Statistical Analysis:

Evaluation of effectiveness

- All quantitative outcome data will be entered into the SPSS database and analysed in relation to change indicators. Measures will be correlated.

Adherence to the model:

- Supervisor's assessment based on the audio recordings of the sessions and clinical notes kept by the counsellors will be used to arrive at the overall rating of the adequacy of the treatment and adherence to the model.

Ethical Issues

The research will take part within an established, evaluated service. Existing patient information sheets and consent forms will be used in line with the PTiPC protocols.

The project will be subject to receiving Ethical approval by the Metanoia Institute Research Committee.

Dr Biljana van Rijn
Head of Clinical Services
Metanoia Institute

REFERENCES:

- Brown, R. A., & Levinsohn, P. M. (1984). A Psychoeducational Approach to the Treatment of Depression: Comparison of the Group, Individual and Minimal Contact Procedures. *Journal of Consulting and Clinical Psychology, 52*(5), 774-783.
- Burlingame, G., Fuhriman, A., & Mosier, J. (2003). The Differential Effectiveness of Group Psychotherapy: A Meta-Analytic Perspective *Group Dynamics: Theory, Research, & Practice 7*(1), 3-12.
- Chen, T. H., Lu, R. B., Chang, A. J., Chu, D. M., & Chou, K. R. (2006). The Evaluation of Cognitive-Behavioral Group Therapy on Patient Depression and Self-Esteem *Archives of Psychiatric Nursing 20*(1), 3-11.
- CSIP (2008). Improving Access to Psychological Therapies (IAPT) Commissioning Toolkit *April 2008*,
- Cuijpers, P., Smit, F., Voordouw, I., & Kramer, J. (2005). Outcome of Cognitive Behaviour Therapy for Minor Depression in Routine Practice *Psychology and Psychotherapy: Theory, Research and Practice 78*(2), 179-188(110)
- Dodding, C. B., Nasel, D., Murphy, M., & Howell, C. (2008). All in for mental health: a pilot study of group therapy for people experiencing anxiety and/or depression and a significant other of their choice *Mental Health in Family Medicine 5*(1), 41-49.

- Flitton, B., Buckroyd, J., & Vassiliou, M. (2006). Developing Social and Emotional Fluency: an Evaluation of a Therapeutic Group for Girls who Attend a School for Students with Complex Needs. *British Journal of Special Education*, 33(4), 180-187.
- Gordon-Garofalo, V., & Rubin, A. (2004). Evaluation of a Psychoeducational Group for Seronegative Partners of Persons with HIV/AIDS. *Research on Social Work Practice*, 14(14), 14-26.
- Himelhoch, S., Medoff, D., & Oyeniy, G. (2007). Efficacy of Group Psychotherapy to Reduce Depressive Symptoms among HIV-Infected Individuals: A Systematic Review and Meta-Analysis *AIDS Patient Care & Stds* 21(10), 732-739.
- Lau, M., & Kristensen, E. (2007). Outcome of systemic and analytic group psychotherapy for adult women with history of intrafamilial childhood sexual abuse: a randomized controlled study *Acta Psychiatrica Scandinavica* 116(2), 96-104.
- Milgrom, J., Negri, L. M., Gemmill, A., McNeil, M., & Martin, P. R. (2005). A Randomized Control Trial of Psychological Interventions for Post Natal Depression. *British Journal of Clinical Psychology*, 44, 529-542.
- Nathan, P. E., Stuart, S. P., & Dolan, S. L. (2000). Research on Psychotherapy Efficacy and Effectiveness: Between Scylla and Charybdis? *Psychological Bulletin November 2000*(126(6):964-981
- Ohlsson, T. (2002). Effects of Transactional Analysis Psychotherapy in Therapeutic Community Treatment of Drug Addicts. *Transactional Analysis Journal*, 32(3), 153-177.
- Piper, W., Ogradniczuk, J. S., Joyce, A. S., Weideman, R., & Rosie, J. S. (2007). Group Composition and Group Therapy for Complicated Grief *Journal of Consulting & Clinical Psychology* 75(1), 116-125.
- Ryan, M., Nitsun, M., Gilbert, N., & Mason, N. (2005). A Prospective Study of the Effectiveness of Group and Individual Psychotherapy for Women CSA Survivors. *Psychology and psychotherapy :Theory, Research and Practice*(78), 465-479.
- Schiraldi, G. (2001). *The Self- Esteem Workbook*: New Harbringer Press.
- Thunnissen, M., Duivenvoorden, H. J., & Trijsburg, R. W. (2002). Experiences of Patients after Short-Term Inpatient Transactional Analysis psychotherapy. *Transactional Analysis Journal*, 31(2), 122-128.

APPENDIX 1

South West London and St George's 
Mental Health NHS Trust

**Sutton and Merton Psychological Services in
Primary Care (PTiPC) – Stepped Care Protocol**

Document Control Summary

Date of Publication:	September 2009
Author:	Service Manager – Donna Hayward-Sussex
Department:	Sutton and Merton PTiPC

CONTENTS

GENERAL INFORMATION

	3
1. Source of Referrals	
2. Referrals Criteria	
3. Clinical Measurements	4
4. Care Planning	5
5. Managing Risk	
6. Referral Process	9
7. DNA Policy	10

ADMINISTRATION PROCESS

	11
1. New Referrals	
2. Client Activates Referral	
3. Discharge of non-activated referrals	
4. System for Reminding Clients of their Appointments	12

STEPPED CARE TREATMENTS

	14
--	-----------

STEPPED CARE PROCESS

	16
1. Triage – All Clients	
2. Step 2 GCBT	17
3. Step 2 cCBT	18
4. Step 2 Groups	
5. Step 2b Groups	19
6. Step 2b Couples Therapy	20
7. Step 3 Groups	
8. Step 3 Individual Sessions	21
9. Follow Up (3 months)	

DIAGRAMS

PTiPC - Stepped Care Model – September 2009	23
PTiPC - Stepped Care Model – At a Glance	24

PROTOCOL DOCUMENT – STEPPED CARE MODEL

GENERAL INFORMATION

1. Source of Referrals

Clients are usually referred by their GP, CMHT, their health professional, or they may self-refer independently.

All referrals are screened by the Clinical Lead of the service to support clinical appropriateness and effectiveness.

2. Referral Criteria

PTiPC provide treatment for people presenting with all anxiety and depressive disorders including:

Acceptance criteria

- Mild / moderate / severe depression (including post-natal depression) except where hospitalization or a multi-modal intervention is required including psychiatric care, or cases of severe recurrent, chronic or treatment resistant depression.
- Specific phobia
- General anxiety disorder (GAD)
- Panic disorder
- Social anxiety
- Single episode trauma post traumatic stress disorder (PTSD)
- Obsessive-compulsive disorder (OCD) with mild or moderate impairment
- Body dysmorphic disorder (BDD) with mild or moderate functional impairment
- Bulimia nervosa and atypical bulimia nervosa
- Anxiety or depressive disorders associated with long-term conditions, including Medically Unexplained Conditions (MUS)
- Patients with long-term conditions with associated anxiety and depressive disorders
- Any person with mild Learning Disability who fulfils the above criteria

Clients who are in need of a psychological therapies service who also have drug and/or alcohol misuse issues will be seen once the management of the drug and alcohol problems has been assessed and treated by an appropriate drug and alcohol agency.

Clients diagnosed with schizophrenia, other psychotic disorders, or personality disorders can be offered a primary care intervention for an episode of anxiety or depression provided their primary condition is currently being successfully managed.

The service accepts people with mild to moderate learning disabilities, and works with local learning disability services where they exist to agree pathways/transitional protocols to ensure that all people with learning disabilities can access services appropriate to their needs'.

Clients who are actively suicidal but assessed as not being at imminent risk will be accepted by the service, provided the GP also provides support in managing the patient's risk (for example, by having regular contact with the patient).

PTiPC is NOT a crisis or emergency service.

Exclusion criteria

The service will not assess and treat people with the following problems where mental health problems are not present as above.

- Severe and enduring mental health problems such as psychotic disorders or personality disorders where these problems are (1) the primary problem or (2) may significantly interfere with treatment for the patient's depression or anxiety disorder
- Chronic fatigue syndrome (ME)
- Chronic pain
- Other physical illnesses
- Age <18 (unless 16 or over and not in full-time education)
- Dependent drug or alcohol users where drug or alcohol use is the primary problem or who are not stable and/or already within structured substance misuse treatment programme (and the service provider shall screen for alcohol abuse)

The service is unable to work with clients who are currently receiving an intervention from another service for example the case is open to a secondary care team with the exception of the New Directions team where this guideline does not apply.

3. Clinical Measurements

Data entry onto the system (IAPTus) is the responsibility of individual staff. Staff are required to collect the minimum data set on a session by session basis in line with the Service Level Agreement (SLA).

The following measurements are used as part of the minimum data set (MDS) and are collected as routine and at every session:

- Patient Health Questionnaire, PHQ9 (for depression)
- Generalized Anxiety Disorder, GAD7 (for anxiety)
- Social Phobia Inventory (SPIN)
- IAPT Patient Experience Questionnaire (PEQ) (collected at the end of therapy)
- Work and Social Adjustment Scale (WSAS)
- IAPT Inclusion and Employment Questionnaire (IEQ)

PHQ-9 Depression Severity

This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively. PHQ-9 total score for the nine items ranges from 0 to 27. Scores of 5, 10, 15, and 20 represent cut off points for mild, moderate, moderately severe and severe depression, respectively.

GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively. GAD-7 total score for the seven items ranges from 0 to 21. Scores of 5, 10, and 15 represent cut off points for mild, moderate, and severe anxiety, respectively.

Disorder-specific data is collected for the following diagnoses:

- | | |
|--------------------------------|---------------------------------------|
| ▪ Social phobia | Social Phobia Inventory, SPIN |
| ▪ Panic disorder / Agoraphobia | Mobility Inventory, MI |
| ▪ Generalised anxiety disorder | Penn State Worry Questionnaire, Penn |
| ▪ Specific phobia | Fear Questionnaire |
| ▪ Health anxiety | Health Anxiety Inventory, HAI |
| ▪ PTSD | Impact of Events Scale-Revised, IES-R |
| ▪ OCD | Obsessive-Compulsive Inventory, OCI |

Clients are given the disorder specific questionnaires (as above) at the following four time points in treatment: (1) Step 3 assessment, (2) 1st treatment session, (3) final treatment session, and (4) three-month follow-up. No disorder-specific measures are given to clients with a primary diagnosis of depression.

4. Care Planning

All clients are case managed by individual staff members. This means that all staff working with clients individually or in groups are responsible for tracking client progress and managing risk. This process assists staff to ensure their clients are stepped up or down according to individual need and that a risk management plan is reviewed at every supervision session.

For Step 2 workers seeing groups jointly with a co-facilitator, one of the two clinicians must be identified as the 'lead clinician', who will be the responsible 'case manager' for all patients in the group. This makes certain that all clients are case managed by one individual and logged in relation to IAPTus.

Employment specialists case manage their clients unless they are working jointly with a clinician, in which case the client is case managed by the clinician. Case management responsibility is transferred to the employment specialist upon completion of the psychological intervention. This process is indicated on IAPTus.

Psychotherapists case manage their clients including 'alerting' the Service Manager or Clinical Lead as well as the Cluster Lead to any issues of risk.

Step 3 staff are responsible for case managing their clients including the management of risk. In circumstances whereby a client is considered to be at immediate risk to themselves or another, the clinician must follow the risk management guidelines.

5. Managing Risk

I. Routine monitoring of client risk

The issue of risk should be addressed in the first individual or group treatment session. The brief assessment should include information about who the client may contact if they feel suicidal - e.g. contact information re their GP and the local A&E department. All staff seeing clients are required to monitor the routine outcome measures that are routinely used at every client contact. All clinicians are required to "keep a close eye" on the following two items: **PHQ9 – item 9** (suicidal thoughts) and **CORE10 - item 6** (plans to end life). If at any time, a client scores **between 1 and 4** on item 6 of the CORE10, **OR** their score on item 9 of the PHQ-9 is **3** (maximum), the case manager (e.g., Step 2 worker, clinician) should arrange to meet with or call the client to discuss their risk. The details of

this discussion should then be entered onto IAPTus in the relevant section and the relevant data be added to the data entry section.

II. Allocation and transfer of case management responsibility

All members of staff will have responsibility for tracking the risk of the clients under their care. The following rules clarify which clients clinicians do and do not hold case management responsibility for.

Triage: Responsibility for tracking the client's risk lies with the Step 2 worker who assessed the client. It is his/her responsibility to address any concerns regarding risk in triage supervision. The Step 2 worker's responsibility relinquishes once the client has started a course of CBT at Step 2 / 3 or when the client is being discharged from the service.

Step 2 computerised or guided CBT: Responsibility for tracking the client's risk status lies with the Step 2 worker who has taken on the client for C/GCBT. It is his/her responsibility to address any concerns about risk in weekly clinical supervision. The Step 2 worker's responsibility relinquishes once the client has been discharged from the service, or once s/he has been seen at Step 2b or at Step 3 for further treatment.

Step 2 mood / anxiety management courses: For each course, a 'lead clinician' must be identified. Responsibility for tracking clients' risk status lies with the Step 2 worker leading the course. S/he is responsible for addressing any concerns about risk in weekly clinical supervision. The Step 2 worker's responsibility relinquishes once the client has been discharged from the service, or once s/he has been seen at Step 2b or at Step 3 for further treatment.

Step 3 assessment: Once the client has been seen for assessment at Step 3, the responsibility for tracking risk moves to the Step 3 clinician who carried out that assessment. It is his/her responsibility to address any concerns of risk in clinical supervision with his/her supervisor. The clinician's responsibility relinquishes once the client has started a course of CBT at Step 3 with another Step 3 clinician, if the client is stepped down and has started a course of treatment at Steps 2 / 2b (groups; computerised or guided CBT), or when the client is being discharged from the service.

Step 3 group CBT: For each CBT group at Step 3, a 'lead clinician' must be identified. Responsibility for tracking risk lies with the lead clinician. It is this clinician's responsibility to address any concerns regarding risk in clinical supervision. The clinician's responsibility relinquishes once the client starts a course of individual CBT at Step 3 with another clinician, if the client is stepped down and has started a course of treatment at Steps 2 / 2b (groups; computerised or guided CBT), or when the client is being discharged from the service.

Step 3 individual CBT: Responsibility for tracking risk lies with the treating clinician. In the majority of cases, this will be the same clinician who carried out the Step 3 assessment. It is the clinician's responsibility to address any concerns regarding risk in clinical supervision. The clinician's responsibility relinquishes once the client has been transferred to another Step 3 clinician, if the client is stepped down and has started a course of treatment at Steps 2 / 2b (groups; computerised or guided CBT), or when the client is being discharged from the service.

Employment specialists: Where clients are seen for assessment or treatment at Step 2 or Step 3 while receiving employment support, responsibility for tracking

risk remains with the treating clinician. Where the employment specialist is the only person in the service having regular contact with the client, it is his/her responsibility to track the client's risk using the MDS questionnaires (see Section I above) and to address any concerns about risk in clinical or case management supervision. The employment specialist's responsibility relinquishes once the client has started a course of treatment with a Step 2 worker or Step 3 clinician, or if the client is discharged from the service.

III. Management of acute client risk

Admin staff should initially direct any emergency calls from clients to the clinician who holds case management responsibility for the client. If the client has been booked in for a triage assessment or they have only very recently been triaged, the Step 2 worker who triaged the person initially or the person who had the client booked in for triage should take the call. The clinician should then go through the following four steps:

Step 1: Establish the client's current level of risk using the standard risk assessment form. Inform the client that we are not an emergency service and will therefore not be able to see him/her immediately.

Step 2a: If the client **has acted on plans to kill himself/herself** (e.g. s/he has taken an overdose of tablets and is telling you this), please contact an ambulance immediately by calling 999. Try to find out exactly what s/he has done (e.g., how many tablets they have taken and of what). Record all this on IAPTus and contact the client's GP to inform him/her of the incident.

Step 2b: If the client tells you that s/he has made **concrete plans to kill himself/herself within the next few hours**, contact the Home Treatment Team (HTT; Tel: 020 8682 6158). Please remember that the HTT should only be contacted if you have justifiable concerns that the client will kill himself/herself within the next few hours unless s/he receives help (i.e., a situation where the client would normally be sectioned under the Mental Health Act). If the clinical service lead is available, approach him/her before calling HTT as s/he is able to discuss all referrals directly with Paul Dewsnap (the clinical lead for HTT) and fast-track the referral. If the clinical service lead is not available, call the HTT directly on the number above to discuss the client and make the referral.

Step 2c: If the **client is not at immediate risk of suicide but you remain concerned about his/her safety**, start by providing the client with the contact numbers of services they should access if they start feeling worse or actively suicidal – Samaritans, A&E and the Crisis Line (0800 028 8000). Next, ask the client to contact his/her GP as soon as possible to arrange an urgent meeting. Inform them that you will also contact the surgery to ensure the GP is expecting the client's call and prioritises it. Finally, ask the client to call you back on your mobile once they have arranged the appointment with their GP.

Step 3: Next, call the client's GP surgery. If you get an admin person on the phone, tell them that you need to speak to the client's GP urgently. If you manage to get hold of the GP, explain that their client has contacted you, tell them what happened and that you would be grateful if s/he could arrange to see the client as soon as possible for a review of their mood and their medication. If the client is not currently prescribed anti-depressant medication, you may suggest that the GP discusses various options for medication with the client at the meeting. If you don't manage to get hold of the GP, leave a message with the admin staff asking for the GP to call you back as soon as possible. Enter all this on IAPTus.

Step 4: Once you have spoken to the GP or left them a message to get back to you asap, put together a brief letter outlining what happened and what you would like the GP to do. The letter should be faxed to the surgery the same day.

Sample letter:

“Dear Dr Robins, (As discussed earlier today,) I was (today) contacted by your client, Mrs Jane Smith, who told me that she has been feeling depressed and suicidal since yesterday evening. Mrs Smith’s suicidal thoughts appear to have been triggered by her husband telling her yesterday morning that he had decided to leave the family. (paragraph) Given the severity of Mrs Smith current symptoms of depression, I would be grateful if you could arrange to meet with her at your earliest convenience to review her mood and her medication. I have asked Mrs Smith to contact the surgery from her side to arrange a meeting and she has agreed to this. (para) As PTiPC is not an emergency service, we are unfortunately not able to see Mrs Smith immediately. However, I have booked her in for a triage assessment with one of our graduate mental health workers on 27th April at 9.30 am *this assumes the client has not already had a triage assessment*. (para) Many thanks for your support. Please feel free to contact me on 07736 818 123 if you require any further information. (para) Yours sincerely, (name of Step 2 worker/clinician)”.

This letter to the client’s GP should be kept brief. Once it has been faxed to the surgery it must be uploaded onto IAPTus.

IV: Tracking identified client risk over time

1. Clients’ risk must be assessed at both Step 2 triage and Step 3 assessment, using the standardised risk tool for triage or the relevant section on the Step 3 assessment form. Where it is identified that a client is at significant risk of harm from self or others, a risk management plan must be agreed. The risk management plan should contain a sequence of steps describing what the client should do if s/he starts feeling actively suicidal. Once the plan has been agreed, the clinician should (1) provide the client with a written copy of the plan and (2) summarise the agreed plan on IAPTus.
2. Following the initial assessment, the client’s risk status must be entered on IAPTus. If subsequent assessments indicate a change in risk status, this must be indicated on IAPTus by changing the relevant entry.
3. The client’s risk status must be briefly summarised on IAPTus. The entry should state clearly the results of the assessment:

Example: “I carried out a risk assessment today. While Ms Smith reports experiencing suicidal thoughts about 1-2x per week, she is adamant that she would not act on these thoughts because of her children”.

4. The client should be given the contact numbers for the Samaritans, the Crisis Line (0800 028 8000), and be informed about the location of their local A&E department.
5. When the client starts his/her course of treatment, the clinician must check in the first treatment session whether or not their risk status has changed since the assessment(s). This should be done by scanning the relevant items on the PHQ9 (item 9) and the CORE (item 6). Where a significant change has occurred (e.g., an increase in the client’s score on item 9 of the PHQ9), the reasons for this change should be discussed with the client and summarised on IAPTus (see Point 3 above). Where further discussion indicates that the

client may be at high risk of self-harm or suicide the clinician must agree a risk management plan with the client (see above).

6. For all subsequent sessions, if a client who has been identified as being at risk of suicide fails to attend a session or misses a pre-arranged telephone call, the responsible clinician must contact the client immediately. If the clinician is unable to get hold of the client, s/he should call the client's GP surgery immediately to inform them that the client has failed to attend the session.
7. While seeing a client in treatment, the clinician must scan the relevant items on the PHQ9 and the CORE at every contact and address any changes in the client's scores with him/her as they occur.
8. In preparation for supervision, supervisees must highlight any clients thought to be at risk of harm to themselves or to or from others on the Patient List by labelling them with the letter 'R' (see revised final column on the latest version of the Patient List, entitled 'priority / risk cases'). It is the supervisee's responsibility to raise any significant risk issues with the supervisor (e.g., change to clients' risk status, client reporting risk behaviour in the session). In addition, the supervisor may choose to discuss particular clients on the basis of their risk status as indicated in the 'priority / risk cases' column.

V. Entering risk information on IAPTus

In all cases of Risk, the specific details of the risk scenario must be entered onto IAPTus in the relevant risk Information section and the nature of the risk must be discussed in supervision. Clients considered at risk to themselves or others are tracked on a weekly basis by the allocated case managing clinician, Step 2 worker or employment specialist. Progress in relation to this will be documented on IAPTus.

If a client at any point during their care pathway is highlighted as a risk (based on PHQ-9 – item 9 (suicidal thoughts), and core10 - item 6 (plans to end life) then this needs to be entered onto IAPTus. If they are not a risk then the default entry is risk = NONE. Other is endorsed if at any point of contact the clinician or Step 2 worker makes a judgment that risk is present based on what the client is saying. Please note the variable next to 'Risk' needs to be filled in with the date at which risk was identified.

6. Referral Process

Employment Service

Clients who have been signed off work for more than one month or clients who are currently unemployed and wish to gain employment are referred to a PTiPC Employment Specialist.

Staff wishing to refer a client to a Specialist will email information relating to the referral directly to one of the Employment Specialists who confirms that they will be making contact with the client, normally within 48hrs. Employment Specialists work with case loads of up to 25 clients at any one time. In the event of a Specialist being unable to take the referral due to capacity, they will take responsibility for passing the referral to a colleague who will in turn confirm with the referring staff that they have received the referral.

CMHT Referrals

Step 1: If following triage a client is deemed more suitable for referral to CMHT, this should be discussed in triage supervision where any decision to refer to CMHT should be made. The supervisor should be able to explain to the

assessing clinician why the CMHT is the most suitable option in this particular case, taking into account that the CMHT will only accept clients whose mental health problems can be considered “severe and enduring”. The assessing clinician should then complete the assessment letter, spelling out clearly why it is thought that the client should be considered by them for an assessment.

Step 2: The assessor should next make a call to the CMHT to speak to one of their clinical staff. They should then raise the main issues highlighted in the letter and check with that person if the referral sounds broadly appropriate for a referral to them. Once this has been agreed, the referral letter is sent with the addition “I discussed Ms X with X (name of CMHT clinician the person talked to) on the X (date), and we agreed that she would be a suitable referral for your team. I am therefore now referring Ms X to you for an assessment”. In the last paragraph, the clinician to write: “Please feel free to refer the client back to PTiPC should they continue to experience problems with anxiety or depression once the above problem(s) has (have) been resolved”.

If the referral is not accepted: If the CMHT does not agree to accept the referral OR the referral gets bounced back by the CMHT following their team meeting, the assessing clinician and the triage lead should re-consider if client does indeed need to be seen by the CMHT or could be seen in PTiPC at Step 3 for an assessment. If concerns remain and it is felt strongly that the CMHT is most suitable service for the patient, the triage lead should approach the clinical service lead to discuss. The clinical service lead may contact the CMHT’s consultant psychiatrist directly to discuss the referral and then make the referral if considered appropriate.

HTT Referrals

As for CMHT, except 1) if the step 2 worker needs more immediate support to speak to the Triage Lead or Clinical Lead and 2) after referral is approved, GP must be contacted via telephone to inform them of urgency and a referral letter faxed to GP and HTT.

Suicidal Cases not for HTT

After discussion in supervision, if accepted for intervention, the step 2 worker (with guidance from supervision) calls the client’s GP to agree that they will have regular contact with the client highlighting that we are not a crisis service. This is also written in the GP letter, and faxed if deemed appropriate in supervision.

Other Agencies

Referral options to external providers can be found on the shared drive in the Referral Directory file.

7. DNA Policy

The following DNA policy applies to all care steps within PTiPC:

- A. Everyone is discharged immediately if they DNA their first appointment without cancelling
- B. Everyone is discharged after a second DNA (without cancelling) during treatment
- C. Clients who cancel more than 3 appointments in any course of treatment are discharged
- D. At Step 2 groups, everyone is discharged if they have not confirmed and DNA their first treatment appt.

Please Note: Non attended sessions by a client considered at risk to themselves and or others must be followed up including alerting the GP.

ADMINISTRATION PROCESS

1. New Referrals

- Admin uploads new referrals and creates new referral form onto IAPTus.
- Letter is sent to the client to remind them to activate their referral. Also included are the PEQ, GAD-7 and PHQ-9 with instructions on how to complete the forms.
- If the client needs an interpreter they are automatically stepped up to Step 3 - relevant to their cluster.
- Referral is placed into the blue boxes in alphabetical order.
- If the client is currently being seen by another service then this is highlighted to the Clinical Lead to check suitability of referral. A letter will be sent to the client and GP explaining why PTiPC are unable to see the client at this time.
- If the client is open to another SWLSTG-TR service, Admin will call the relevant service to ascertain if they are still being seen. If they are not they are asked to discharge the client. If the client is still undergoing treatment with the other team a letter explaining that PTiPC are unable to proceed with the referral is sent to the client and GP.

2. Client Activates Referral

- Admin checks that referral has been received – also asks if client has the clinical measures and advises them to hold onto them for triage if they do. If measures have been previously sent in the post, admin to attach to the referral before triage. (There is a separate folder next to the triage folder, which holds the questionnaires. Before the GMHW or LIT conducts the triage they will collect the forms, if received.
- If the referral is received and open on IAPTus, admin books triage appointment with the client on the telephone using the excel diary.
- In the event that admin has not received a referral, admin completes referral form cross-checking in case the GP has subsequently sent the referral form.
- The client is required to wait two days, as stated on the referral form. If activation occurs before referral has been screened and uploaded client advised to ring back in two days. This protocol is in place to ensure that there is no possibility of doubling up.
- Admin ensures the entry in IAPTus – activation date as “Referral accepted” date in the referral details to demonstrate the client has activated.
- The referral is filed in the triage cabinet in alphabetical order.

3. Discharge of non-activated referrals

There are 4 blue boxes marked weekly in 4 consecutive weeks. Admin discharges referrals remaining in earliest of the four boxes every week. This is **only** after cross checking on IAPTus that the client did not activate before GP sent through referral. On occasions when there is a low uptake of appointments admin or a step 2 worker call/text clients to remind them to activate their referral. Cancellations rescheduled by admin and step 2 workers will be entered into IAPTus progress notes. New appointment is scheduled by Admin and entered into excel diary, file returned to triage cabinet.

- If the Client DNA's (when triaged) they are then booked in for an appointment 2 weeks after their triage date. A letter is then sent out with the date of their new appointment.
- If a client is discharged and they ring to re-activate their referral admin will activate their referral on IAPTus. The GP does not need to re-send another referral, unless a 2 month lag has occurred.
- If a client was triaged (recently) and discharged and has come back to PTiPC wanting to be seen again (within 2 months) another triage booking with a step 2 worker takes place for approximately 15 minutes. This brief triage is to establish if the client's clinical measurement scores have changed. Decisions about the clients treatment plan are then discussed in triage supervision.
- In the event that a client has been triaged and or received treatment by PTiPC over two months ago, they will automatically have a full triage assessment. Also if client has been seen by PTiPC and discharged and this was more than 3 months ago (when they ring) a new referral needs to be sent by GP.

4. System for Reminding Clients of their Appointments

All PTiPC members of staff have an NHS.net email account, which is used to send confidential information to each other but mainly to send text messages (SMS) to clients (who have mobiles) to remind them about assessment appointments, groups, individual sessions etc. in order to minimise DNA rates at all levels.

The following standard text messages are used by Step 2 staff to remind patients of appointments:

Activate Referral

Please remember to activate your referral for Psychological Therapies on 0208 254 1043. *Please do not reply to this Text*

New Appointment Texts for Triage

This is to confirm that your next appointment with Psychological Therapies is X/X/09 @ 11:30am. If you cannot make this telephone assessment, please call this number 0208 254 1043. * Please do not reply to this Text*

DNA of triage appointment

We tried to contact you today for your pre-booked telephone assessment. Your next appointment with Psychological Therapies is X/X/09 @ 11:30am. If this is not convenient please call 0208 254 1043. If you miss this appointment we will have to discharge you back to your GP. *Please do not reply to this Text*

Group

Please remember that you have a Group this Monday X/X/09 @ 14:00 at the Nelson Hospital. If you cannot make this appointment, please call XXXXXXXX. *Please do not reply to this Text*

Guided CBT

Please remember that you have Guided Cognitive Behaviour Therapy this Monday X/X/09 @ 14:00. If you cannot make this appointment, please call XXXXXXXX. *Please do not reply to this Text*

The following standard text messages are used by Step 3 staff to remind patients of appointments:

Step 3 Assessment Appointment

This is to confirm that your next appointment with Psychological Therapies will be on X/X/09 @ 11:30am. If you cannot make this appointment, please call this number 0208 254 1043. * Please do not reply to this Text*

Group CBT

Please remember that you have a Group this Monday X/X/09 @ 14:00 at Amity Grove. If you cannot make this appointment, please call XXXXXXXXXXXX. *Please do not reply to this Text*

Individual CBT

Please remember that you have an appointment with XX this Monday X/X/09 @ 14:00. If you cannot make this appointment, please call XXXXXXXXXXXX. *Please do not reply to this Text*

Follow-up session

Please remember that you have a telephone follow-up appointment with XX this Monday X/X/09 @ 14:00. If you cannot make this appointment, please call XXXXXXXXXXXX. *Please do not reply to this Text*

In the case of Step 3 assessments, all qualified staff are encouraged to call patients before the appointment to (1) briefly introduce themselves and engage the client, and (2) confirm with the patient their attendance of the appointment.

Stepped Care Treatments

In order to achieve the best recovery outcomes, PTiPC provides specific manual-based CBT interventions as described below:

Depression:

At **step 2a** individuals experiencing mild to moderate depression are offered either a) step 2 group-based CBT, or b) individual guided self-help based on the Five Areas approach (depression) developed by Chris Williams and colleagues; computerised CBT is also available. Clients are offered a choice between (1) 6 one hour sessions of group-based CBT, (2) 6 half-hour sessions of guided self-help, or (3) 8 sessions of telephone-assisted cCBT.

At **step 2b** if clients are experiencing mild to moderate depression but have not responded to a low intensity intervention, they are stepped up to either 16 weeks of psychotherapy for depression or, if their problems exist in a couple relationship, to systemic therapy. If clients symptoms do not remit with these treatments they will be stepped up to step 3.

At **step 3** people with depression receive group or individual CBT following the approach developed by Beck and colleagues; individual behavioural activation (BA) following the approach developed by Martell and colleagues. They are offered group based intervention initially but if symptoms persist may be stepped up again to receive up to 20 sessions of individual CBT. Treatment is guided by: CBT - Beck et al. (1979); Fennell (1989); Fennell, Bennett-Levy & Westbrook (2004).

Panic Disorder:

At **step 2** individuals are offered a choice between either a) six one-hour sessions of group-based CBT, or b) four half-hour sessions of guided self-help based on the Five Areas approach (anxiety) developed by Chris Williams and colleagues; or c) six sessions of telephone-assisted computerised CBT. Treatment is guided by: Williams (2003). Individuals whose symptoms do not remit with this treatment will be stepped up to step 3.

At **step 3** people with panic disorder always receive individual CBT following the approach developed by DM Clark and colleagues. Clients may be stepped up to 20 sessions if their symptoms persist after 7 sessions. Treatment is guided by: Clark (1996); Hackmann (2004); Wells (1997).

Generalized Anxiety Disorder:

At **step 2** individuals are offered a choice between either a) six one-hour sessions of group-based CBT, or b) four half-hour sessions of guided self-help based on the Five Areas approach (anxiety) developed by Chris Williams and colleagues. Individuals whose symptoms do not remit with this treatment will be stepped up to step 3.

At **step 3** Clients will be offered group CBT following the approach developed by Barlow and colleagues. Clients may be stepped up to 20 sessions of individual therapy if their symptoms persist. Treatment is guided by: Craske & Barlow (2006); Zinbarg, Craske & Barlow (2006).

Social Phobia:

There is no recommended step 2 intervention for social phobia and all patients will immediately be offered individual CBT at **step 3** following the approach developed by Clark and Wells. Patients are seen for up to 20 sessions. Treatment is guided by: Butler & Hackmann (2004); Clark (2001); Wells (1997).

Post-Traumatic Stress Disorder (PTSD):

There are no recommended step 2 interventions for PTSD and all clients will immediately be offered individual trauma-focused CBT at **step 3** based on the approach developed by Foa and colleagues. Patients are seen for up to 20 sessions. If presentation is clinically complex and/or no response after 20 sessions, referral to Traumatic Stress Service (tertiary) via CMHT. Treatment is guided by: Foa & Rothbaum (2001); Foa, Hembree & Rothbaum (2007); Rothbaum, Foa & Hembree (2007).

Obsessive Compulsive Disorder (OCD):

At **step 2** individuals are offered a choice between either a) 6 half-hour sessions of guided self-help or b) 8 one-hour sessions of group-based CBT following the approach developed by Foa and colleagues. Treatment is guided by: Foa & Wilson (2001).

At **step 3** all clients will receive individual exposure-based CBT based on the approach developed by Foa and colleagues. Clients are seen for up to 20 sessions. If presentation is clinically complex and/or no response after 20 sessions, referral to specialist OCD service (BCPU, Springfield Hospital) via CMHT. Treatment is guided by: Foa & Kozac (2004a, 2004b); Foa & Wilson (2001).

Employment Related Problems:

At all **steps** clients have access to a specialised employment service dedicated to specifically working with 'hard to reach' clients. These will be clients who have been signed off work for more than one month or clients who are currently unemployed and wish to gain employment.

Three month follow-up (FU) appointments

It is standard practice for all clients who have received a psychological intervention to receive a follow up call from a clinician 3 months after being discharged from the service. This is done to ascertain information about the client's wellbeing.

STEPPED CARE PROCESS

The stepped care model applies to all clients accessing the service and supports the following objectives:

1. Treatment should always have the best chance of delivering positive outcomes while taking up as little time as possible.
2. A system of scheduled review to detect and act on non-improvement must be in place to enable stepping up to more intensive treatments, stepping down where a less intensive treatment becomes more appropriate, and stepping out when an alternative treatment or no treatment become appropriate.

1. Triage – All Clients

Generally triage is carried out by a GMHW or Low Intensity Trainee (LIT). The step 2 worker checks RIO (for previous referral, open referral in secondary care or re-referred) and discharges if required. Discharging a client from RIO must only occur on a PTiPC case load to avoid discharging the client from another team.

In the event of a client DNA

- If the client is not available the step 2 worker calls again in 5 minutes – leaving a message if necessary. No details about the service are to be left on the answerphone. This supports client confidentiality.
- If on the second attempt there is no answer, the client is either sent a letter or a text (if they have a mobile number) via nhs.net informing them of the date and time of their next appointment. The letter sent is the standard “DNA once” letter and is copied to client’s GP. Information in the letter includes notifying the client of the new time allotted and asking them to cancel with 24 hours notice on the “activation” line.
- The letter is uploaded on to IAPTus and the DNA and new appointment information is entered into IAPTus progress notes **and** the appointment entered in the Triage excel diary.

If a client DNAs twice

- Step 2 worker writes a standard “DNA twice” discharge letter to GP and copies it to the client.
- The step 2 worker uploads the letter onto IAPTus.
- Progress notes are updated with DNA.
- The client is discharged on IAPTus .
- The GP letter is placed into GP folder.

If client begins triage but does not complete

- A further appointment is booked and entered into the excel diary (with the same person wherever possible).
- Progress notes are completed.
- A discussion/exploration takes place in triage supervision if needed.

If client answers the phone, but says they do not have enough time for triage appointment, or forgot etc.

- The appointment is counted as a DNA and entered into IAPTus as such.
- Another appointment is scheduled and entered into the Triage diary.
- IAPTus progress notes updated.

Completed triage

- It is standard practice that all Step 2 workers attend triage supervision daily. This ensures the rationale for all decisions made including referrals and sign posting. Those experienced in triage are allowed to make decisions on clear Step 2 interventions without supervision (e.g. mild to moderate scores, no risk). Treatment decisions are based on the least intrusive/brief intervention as per NICE guidance.
- Progress notes are completed using the standard template.
- Following supervision if the client is referred to a Step 2 group intervention, then the Step 2 worker books the client into the first Step 2 appointment, confirms appointment with client on phone, or asks to confirm. In the case of GCBT the person is added to the waiting list.
- If the client is being referred for a Step 3 assessment the Step 2 worker books the client directly into the Step 3 assessment booking system, sends appointment letter for appropriate clinician to patient, uploads letter onto IAPTus and updates progress notes.
- A standard letter is compiled to the GP and the client with details of the triage summary and first appointment (if approp.) following the Triage letter guidelines.
- The letter is uploaded onto IAPTus.
- Diagnosis is added.
- The GP letter is placed into GP folder and patient letter sent to patient.
- If the client is referred to GSH a tracking sheet is completed and placed in the waiting list folder.

2. STEP 2 (GCBT – 6 sessions)

Mild to Moderate Conditions

If clients present with symptoms of depression and anxiety of mild to moderate severity, their day-to-day functioning is not impaired or only mildly impaired as a result of the problem. The intervention is deemed least intensive and easiest to access, and most appropriate at the time.

Outcome Measures Guidance: The client's overall scores on either the PHQ-9 or the GAD-7 are between 5 and 9. In some circumstances the outcome measure scores will be higher and if deemed appropriate the client should still be offered GCBT.

Structure of sessions: The first session of Guided Cognitive Behavioural Therapy is generally undertaken face-to-face and takes 1 hour. This first direct contact helps clients to stay engaged with the self-help programme through the forthcoming weeks. The remaining sessions (5 sessions) are then conducted over the phone and involve working through a series of materials over several weeks with the help of the therapist. Each phone session lasts up to 30 minutes.

Clients are discharged after 6 sessions of GCBT unless it becomes apparent at the penultimate session that the patient has not been able to benefit from the

treatment (e.g., no improvement in scores on the PHQ-9 or GAD-7; verbal feedback from the client), or a slight deterioration of symptoms has taken place. In this case the client should either (1) be referred to another service as appropriate or (2) stepped up to Step 2 or 2b groups depending on the outcome of supervision. (3) In rare cases of a severe deterioration of symptoms (which may occur due to external changes outside the therapist's control), the client should be offered a Step 3 assessment.

Please Note:

The minimum data set has to be completed at every session and entered onto IAPTus. Clients should be discharged from the service on completion of their treatment.

3. STEP 2 (cCBT – 8 sessions)

Mild to Moderate Conditions

The client presents with symptoms of depression and anxiety of mild to moderate severity and their day-to-day functioning is not impaired or only mildly impaired as a result of the problem. The intervention is deemed least intensive and easiest to access, and most appropriate at the time.

Outcome Measures Guidance: The client's overall scores on either the PHQ-9 or the GAD-7 are between 5 and 9. In some circumstances the outcome measure scores will be higher and if deemed appropriate the client should still be offered telephone assisted cCBT.

Clients are discharged after 8 sessions of cCBT unless it becomes apparent at the penultimate session that the patient has not been able to benefit from the treatment (e.g., no improvement in scores on the PHQ-9 or GAD-7; verbal feedback from the client), or a slight deterioration of symptoms has taken place. In this case the client should either (1) be referred to another service as appropriate or (2) stepped up to Step 2 or 2b groups depending on the outcome of supervision. (3) In rare cases of a severe deterioration of symptoms (which may occur due to external changes outside the therapist's control), the client should be offered a Step 3 assessment.

Please Note:

The minimum data set has to be completed at every session and entered onto IAPTus. Clients should be discharged from the service on completion of their treatment.

4. STEP 2 (Groups 6 sessions)

Mild to Moderately Severe Conditions

The client presents with depression or anxiety of mild to moderate severity, their day-to-day functioning is not impaired or only mildly impaired as a result of the problem, and psycho-educational support is considered most appropriate at the time. Exclusions are diagnoses of social phobia, post-traumatic stress disorder (PTSD), and moderate to severe levels of obsessive-compulsive disorder (OCD), as these problems do not respond well to group-based CBT.

Outcome Measures Guidance: Client's score on the PHQ-9 is between 5 and 19. Client's score on the GAD-7 is between 5 and 15.

The client will normally be discharged after 6 sessions of group work unless at the penultimate session it is apparent that no clinical change has occurred or a

deterioration has taken place, in which case the client should either be referred to another service if appropriate or stepped up to Step 2b or 3b depending the outcome of supervision.

In general, clients who present with a need to be stepped up will be offered a Step 2b intervention if their PHQ-9 and GAD-7 score is between 5 and 14.

In rare cases of a severe deterioration of symptoms (which may occur due to external changes outside the therapist's control), the client will be offered a Step 3b intervention (individual course of CBT) and therefore will proceed directly from Step 2 to Step 3b.

Please Note:

The minimum data set has to be completed at every session and entered onto IAPTus. Clients should be discharged from the service on completion of their treatment.

5. STEP 2b (Psychotherapy Groups – 16 sessions)

Mild to Moderate Conditions

Following a step 2 or 3 intervention, further treatment is deemed clinically appropriate, and the client's scores on the outcome measures PHQ-9 and GAD-7 are below 15 and 16, respectively. Clients must present with a mild to moderate mental health difficulty including depression. It must also be apparent that the client has the potential to benefit from a time-limited psychotherapy intervention.

Clients must demonstrate the following:

- An ability to set and work toward a clear goal.
- A working level of psychological-mindedness and emotional availability.
- A level of cognitive ability sufficient to support the psychotherapy process.
- An understanding and acceptance of the level of the commitment required to build and sustain a therapeutic relationship and to work within a group process.
- Respect for the therapeutic environment and those within it.
- An expressed motivation for personal change.

Clients will be discharged after 16 sessions of group work unless at the penultimate session it is apparent that no clinical change has occurred or a deterioration has taken place. In this case the client should either be stepped up to Step 3b depending on supervision and a discussion with the Clinical Lead or be referred to another service if appropriate.

Staff wishing to refer a client to the psychotherapy groups must complete the PTiPC Referral for Psychotherapy Form located on the shared drive in the Step 2b – Psychotherapy Groups folder. Once completed this is emailed to admin for processing.

Please Note:

The minimum data set has to be completed at every session and entered onto IAPTus. Clients should be discharged from the service on completion of their treatment.

6. STEP 2b (Systemic Couple Therapy – 15 to 20 sessions)

Mild to moderate-severe conditions

This intervention can be considered if following a Step 2 group or GCBT intervention further input is deemed clinically appropriate and the client's scores on the PHQ9 and GAD7 questionnaires are below 15 and 16 respectively. Clients will typically present with mild to moderate-severe mental health difficulties, including depression. An additional key criterion for clients to be considered for this treatment is that their partner might be willing to consider joining them for the therapy sessions.

More specifically, clients and their partners must demonstrate the following:

- The client must have a current partner
- The client may be in a heterosexual, gay, or lesbian relationship.
- The client's partner must be willing to consider joining the client and the therapist for the majority of therapy sessions.
- The couple are able to work together on specific therapeutic goals.
- There is no evidence of current domestic violence.

Clients will be discharged after 15-20 sessions of treatment and a follow-up session will be arranged in 3 months time. At follow-up, progress will be briefly reviewed and the client will be asked to complete the routine outcome questionnaires. If it is apparent from the client's scores on the PHQ9 and GAD7 that no clinical change has occurred or a deterioration of symptoms has taken place, the client will be booked in for a triage assessment, thereby starting a new care episode.

The treatment offered is based on the NICE-supported manual entitled "Systemic couple therapy and depression" by Elsa Jones and Eia Asen (2000)

Please note:

If the client perceives the relationship with (1) their family of origin (e.g., father, mother, siblings) or (2) their own children as having a significant role in the maintenance of their current emotional difficulties, a referral to the Family Therapy Service at Springfield Hospital may be considered.

The minimum data set has to be completed at every session and entered onto IAPTus. Clients should be discharged from the service on completion of their treatment.

7. STEP 3 (Groups 8 sessions)

Moderate to Severe Conditions

Clients presenting with moderate to severe mental health difficulties including depression and anxiety. The available evidence should suggest that the client would benefit from a time limited CBT intervention and it is deemed clinically appropriate.

Outcome Measures Guidance:

PHQ-9 score of 20 or above and/or GAD-7 score of 16 or above.

Clients will typically be discharged after 8 sessions of CBT group work unless at the penultimate session it becomes apparent that no clinical change has occurred or the client's problems have worsened. In these circumstances the client should either be referred to another service if appropriate, stepped down to 2b for group psychotherapy (except those who have already had a step 2b intervention) or stepped up to a Step 3b intervention. The final decision should be reached in case management supervision with the senior CBT therapist

supervising the clinician, who will ultimately obtain final agreement from the Clinical Lead when necessary.

Please Note:

The minimum data set has to be completed at every session and entered onto IAPTus. Clients should be discharged from the service on completion of their treatment.

8. STEP 3b (Individual Sessions 6 to 20 sessions)

Moderate to Severe Conditions

This step is usually offered after clients presenting with severe levels of depression or anxiety (as measured by the PHQ-9 or GAD-7) have undergone treatment at either, Steps 2, 2b and/or 3, and their scores have not sufficiently improved for them to be discharged. This step is also offered to clients who present at triage with the types of anxiety problems that require a one-to-one intervention (i.e., PTSD, social phobia, moderate to severe OCD),

Outcome Measures Guidance:

PHQ-9 score of 20 or above and/or GAD-7 score of 16 or above. On occasions the clients outcome measure has decreased significantly from triage assessment to step 3 assessment. In these circumstances the client should be stepped down to step 2 in accordance with stepped care guidance.

Client will in the first instance be offered up to **6** sessions of individual therapy with a qualified clinician. Depending on patients' needs clinicians may offer two additional sessions (to a maximum of 8).

A small percentage of clients will require further sessions, and requests for additional sessions will be agreed directly with the Clinical Lead. This process ensures that the available resources are used most efficiently, and that there is a clear treatment plan in place for those clients requiring additional treatment.

Clients are discharged following a step 3b intervention unless at the penultimate session it becomes apparent that their symptoms have worsened. In these circumstances they may be (1) offered another course of a Step 3b intervention, or (2) referred to another clinical service if appropriate. Any course of action will be agreed directly with the Clinical Lead.

Please Note:

The minimum data set has to be completed at every session and entered onto IAPTus. Clients should be discharged from the service on completion of their treatment.

9. Follow-up (3-month)

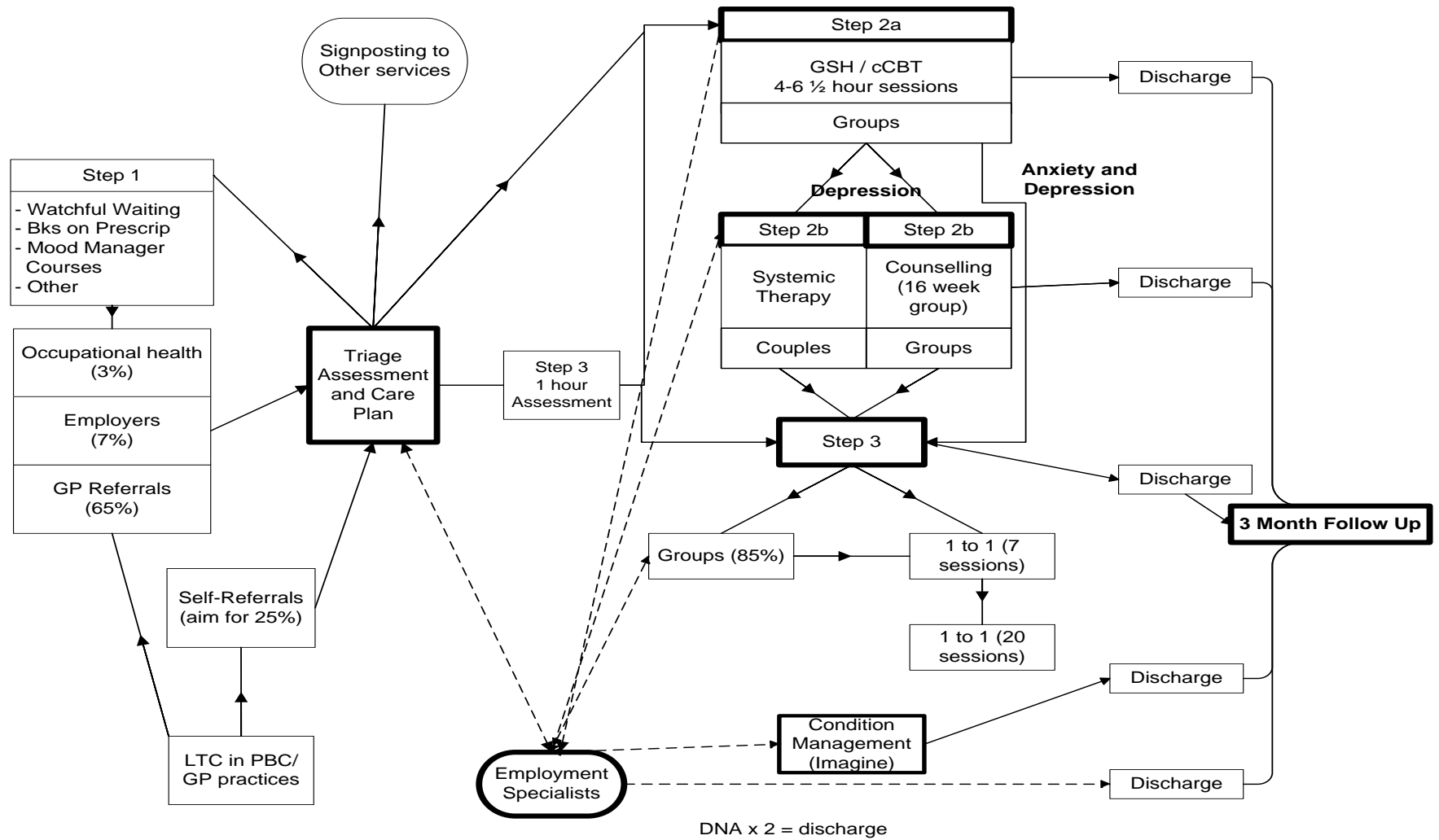
It is standard practice that all clients who have received a psychological intervention will receive a follow up call 3 months after being discharged from the service. This is to ascertain the extent to which they have been able maintain or extend the gains they have made during treatment, and to consider whether booster sessions or another course of treatment may be required.

Arranging and making the follow-up call: In the penultimate or final session, client and therapist agree the date for a 15-30 minute follow-up call, which will take place in 3 months time. The agreed time and date are then noted down by both therapist and client. The therapist provides the client with the relevant questionnaires to take away and fill out on the day of the follow-up call.

After the session, the therapist enters the date and time of the follow-up call in IAPTus and adds a relevant sentence to the discharge letter (e.g., “I have arranged with Mrs X that we will have a follow-up telephone session in 3 months time. In particular, we have agreed that I will call her Monday 27th February at 12.30 pm. This will allow us to review Mrs X’s progress to date, and consider further options for treatment should this be necessary.”). A copy of the discharge letter is then placed by the clinician into the relevant file (see master file named “Follow-ups” on the shared drive) for the relevant month when the FU call should take place (e.g., April, May, June). This is done in order to ensure that (1) the follow-up appointment does not get forgotten even if a therapist loses his or her diary, and (2) if the treating therapist leaves the service another therapist can track which follow-up calls still need to be made.

Structure of the follow-up call: The clinician or Step 2 worker starts the call with a brief introduction and update, and then quickly moves on to talking about the reason for the call “I would like to briefly discuss with you today how things have been going since we last met. However, is it OK if we start with how things have been going over the last week?” The therapist should then go through the questions from the MDS questionnaires and the disorder-specific measures (where appropriate). If it turns out that (1) the client’s scores on either the PHQ-9 or the GAD-7 are in the moderate to severe or severe range, (2) the client’s score on the disorder-specific measure is in the clinical range, (3) the client is significantly at risk currently, OR (4) there are other clear indicators that the client has had a recent major setback, the therapist/step 2 worker will arrange for the client to self-refer and book a triage assessment.

PTiPC - Stepped Care Model – September 2009



PTiPC – Stepped Care Model – September 2009

Details	Step 2	Step 2	Step 2b	Step 3	Step 3
Level and Conditions	Interventions for mild conditions	Interventions for mild to moderately severe conditions	Interventions for mild to moderate conditions	Interventions for clients with moderate to severe conditions. Client has not gained sufficient benefit from at least one brief psychological treatment or it is deemed appropriate to be offered a Step 3 intervention at the start of treatment.	Interventions for clients with moderate to severe conditions. Client has not gained sufficient benefit from at least one brief psychological treatment or it is deemed appropriate to be offered a Step 3 intervention at the start of treatment.
Outcome Measures	Outcome Measures PHQ-9 and GAD-7 are between 5 and 9	Outcome Measures PHQ-9 is between 5 and 19 and GAD-7 is between 5 and 15	Outcome Measures PHQ-9 and GAD-7 are below 15 and 16 respectively	Outcome Measures PHQ-9 is normally above 20 and GAD-7 is 16 and above	Outcome Measures PHQ-9 is normally above 20 and GAD-7 is 16 and above
Interventions	GCBT – 6 sessions cCBT – 8 sessions	Psycho-educational groups for anxiety and depression – 6 sessions.	16 sessions of group psychotherapy or individual couples therapy if appropriate.	8 sessions of high intensity group CBT.	One to one high intensity group CBT. Maximum 8 sessions.
Review	Case review needed for step up.	Case review needed for step up.	Case review needed for step up.	Case review needed for step up or down.	Case review needed for step up or down.