iapt

Improving Access to Psychological Therapies

Commissioning IAPT for the whole community

Improving Access to Psychological Therapies

November 2008

Commissioning IAPT for the whole community

Improving Access to Psychological Therapies

November 2008

Contents

Executive summary

This document is intended to assist commissioners (including practice-based commissioners) to deliver Improving Access to Psychological Therapies (IAPT) services that are effective and appropriate for the whole community, using innovative ways of meeting the needs of local people.

It is drawn from the work of the IAPT special interest groups (SIGs), which have considered the following sections of the community:

- black and minority ethnic communities;
- older people;
- people with medically unexplained physical symptoms;
- people with long-term conditions;
- people with perinatal mental health issues;
- offenders;
- veterans;
- people with learning disabilities; and
- children and young people.

These groups are not exhaustive. Commissioners may need to focus on different areas that reflect their local population, so that IAPT services are appropriate for everyone who needs them. A joint strategic needs assessment (JSNA) will provide a firm foundation for identifying a locality's priority areas and commissioning intentions to address them.

Special interest group issues

The work of the SIGs has shown that there are a number of common themes that should be taken into consideration when commissioning an IAPT service that is appropriate for the whole community. These themes are:

- understanding the needs of the local community;
- removing barriers to access; and
- engaging with different communities.

The SIGs also identified particular issues relevant to their own areas of interest. Commissioners should be aware of the common themes emerging from all the SIGs and the particular needs of different groups in order to ensure that IAPT services meet their needs effectively. Additional information is available in the IAPT Positive Practice Guides on the IAPT website (www.nhs.uk/iapt).

Training and developing the workforce

It is an important principle that the IAPT workforce should reflect and be representative of the local community. The capacity and capability of therapists, as with all health professionals, must be appropriate for the people they will be serving. In order to achieve this, commissioners should understand their local population and its demographic profile, so they can commission an IAPT service of appropriate size, with the appropriate skill mix of therapists.

Practice-based commissioning

Practice-based commissioning (PBC) is about engaging GP practices and other primary care professionals in the commissioning of services. Through PBC, front-line clinicians are being provided with the resources and support to become more involved in commissioning decisions.

Commissioning for outcomes

Routine collection of outcomes data is fundamental to effective delivery of IAPT services. The ongoing management of patient outcomes is important for commissioners to monitor the performance of IAPT services. Outcomes data should be used to ensure that the right service is being delivered to the right people, at the right time with the right results.

Acceptability of different treatment options

While it is imperative that IAPT services provide evidence-based psychological therapy treatments recommended by the National Institute for Health and Clinical Excellence (NICE), it is also important that individuals accessing IAPT services have a choice of treatments that are appropriate to their needs. A system that ensures robust collection of outcome measures enables IAPT services to identify the most effective psychological therapy to offer to individuals from specific communities.

Moving forward

Commissioners have a duty to ensure that IAPT services are available and appropriate to everyone in the local community, including individuals from hard-to-reach groups. In commissioning and designing IAPT services, commissioners should ensure that services adhere to the relevant legislation and principles that eliminate unlawful or unjustifiable discrimination and promote equality of opportunity

The relevant IAPT Positive Practice Guide, together with the IAPT Equalities Impact Assessment and Equalities Toolkit provide additional information and practical guidance for commissioners.[1]

---

1   Available at www.nhs.uk/iapt

1 Introduction

Background

1.1 The Improving Access to Psychological Therapies (IAPT) programme has one principal aim: to help primary care trusts (PCTs) implement National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders.

1.2 In the October 2007 Comprehensive Spending Review, the Secretary of State for Health announced additional funds to begin to improve access to psychological therapies across England:

- £33 million in 2008/09;

- a further £70 million to a total of £103 million in 2009/10; and

- a further £70 million to a total of £173 million in 2010/11.

1.3 These funds will deliver a major training programme providing suitably qualified psychological therapists. This workforce will enable the NHS to progressively expand provision of NICE-compliant local psychological therapy services to people suffering from depression and anxiety disorders.

1.4 The additional resources are linked to a specific set of delivery commitments made by the Secretary of State, including numbers treated, numbers of therapists trained and employment outcomes.[2] The IAPT key performance indicators provide the agreed mechanism for demonstrating regional and national progress against these commitments.

Aim of this document

1.5 This document is designed to complement the IAPT Commissioning Toolkit,[3] launched in April 2008. It is good practice guidance and aims to assist commissioners (including practice-based commissioners) in delivering IAPT services that are effective and appropriate for

---

2 http://nds.coi.gov.uk/environment/fullDetail.asp?ReleaseID=321341&NewsAreaID=2&Navigate dFromDepartment=False)

3 www.iapt.nhs.uk/2008/04/improving-access-to-psychological-therapies-iapt-commissioning-toolkit/

the whole community, using innovative ways of meeting the needs of local people. It is intended for all PCTs, including those already receiving additional national funds for IAPT and those preparing to deliver IAPT services over the next few years.

1.6   It is the work of IAPT special interest groups (SIGs), established to support the 11 IAPT Pathfinder sites who sought to implement IAPT services for the whole community from October 2007.

1.7   Each Pathfinder explored the needs of one or more particular group in its local population. The groups included children and young people, people with perinatal mental health issues, black and minority ethnic (BME) groups, older people, offenders and those with long-term conditions and/or medically unexplained physical symptoms.

1.8   They explored particular issues relating to their community group(s), such as:

- the policy and legal framework;

- barriers to access;

- issues of engagement; and

- the benefits of establishing IAPT services.

1.9   These issues are summarised in the document, which identifies areas that will help in commissioning IAPT services that meet the needs of the following particular groups:

- BME groups;

- older people;

- people with medically unexplained physical symptoms;

- people with long-term conditions;

- people with perinatal mental health issues;

- offenders;

- veterans;

- people with learning disabilities; and

- children and young people.

1.10   This is not an exhaustive list. Commissioners will need to ensure that IAPT services are available and effective for the full range of community groups in their locality.

Special interest group issues

1.11   The work of the SIGs has shown that there are a number of common themes that should be considered when commissioning an IAPT service that is appropriate for the whole community. These are:

- understanding the needs of the local community;

- removing barriers to access; and

- engaging with different communities.

1.12   In addition to these common themes, the SIGs identified particular issues relevant to their own areas of interest. Commissioners should be aware of the common themes emerging from all the SIGs and the particular needs of different groups in order to ensure that the IAPT service meets their needs effectively.

1.13   Further detailed information about all of the issues raised by the SIGs can be found on the IAPT website (www.nhs.uk/iapt).

2 Principles of effective commissioning

2.1   The Department of Health *Commissioning Framework for Health and Well-being* (2007)[4] highlights the need for commissioning services that are personal, are sensitive to individual need, and maintain independence and dignity.

2.2   The Commissioning Framework identifies eight steps to effective commissioning, based on understanding the needs of the local populations and individuals.

Eight steps to effective commissioning

- Putting people at the centre of commissioning

- Understanding and planning for the needs of individuals and of the local population

- Sharing and using information more effectively

- Assuring high-quality providers for all services

- Recognising the interdependence between work, health and well-being

- Developing incentives for commissioning for health and well-being

- Making it happen: local accountability

- Making it happen: capability and leadership

2.3   The Department of Health World Class Commissioning initiative aims to improve commissioning capability of the local NHS by ensuring that improving health and well-being outcomes from available resources is at the heart of delivering services. As world-class commissioners, PCTs will need to develop the knowledge, skills, behaviours and characteristics that underpin effective commissioning.

2.4   World-class commissioning competencies emphasise the importance of the joint strategic needs assessment (JSNA), together with an

---

4   www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/ dh_072604

assurance system, to drive PCTs' commissioning strategies and their collaborative work with community partners. World-class commissioning is an important delivery vehicle for IAPT.

2.5   The competencies also emphasise the need for public and patient engagement. The commissioning competencies are summarised below.

World-class competencies for PCTs

- Locally lead the NHS.

- Work collaboratively with community partners.

- Engage with the public and partners.

- Collaborate with clinicians to inform strategy, service design and resource utilisation.

- Manage knowledge and assess current and future needs.

- Identify and prioritise investment requirements and opportunities.

- Influence provision to meet demand and secure outcomes.

- Drive continuous improvement in quality and outcomes through innovation.

- Deploy procurement skills that ensure providers have appropriate contracts.

- Manage the local health system.

- Make sound financial investments.

2.6   The Local Government and Public Involvement in Health Act 2007 places a duty on local authorities and PCTs to undertake JSNAs, which provide a firm foundation for commissioning that improves health and social care provision and reduces inequalities.

2.7   JSNAs will enable the actions required to deliver a positive impact on health and well-being for the local community. They can be used by commissioners to identify whether services have delivered what was expected, and whether service users have had their needs met.

2.8   JSNAs will identify areas for priority and action with local community partners through local area agreements. They can help commissioners (including practice-based commissioners) to specify outcomes that encourage local innovation and help providers shape services to address the needs of the local people.

3 Understanding the needs of the local community

3.1   The JSNA will enable commissioners to understand the demographic profile and epidemiological data for their local community. In support of this process, the SIGs identified a number of useful sources of information that will help commissioners to provide IAPT services appropriate for the whole population:

- the 2001 Census provides some data about communities in the local area (www.statistics.gov.uk);

- the regional public health observatory (www.apho.org.uk/);

- the Office for National Statistics and other relevant government websites (www.statistics.gov.uk/default.asp);

- the planning or economic development department in the local council;

- data published in journals or magazines of local organisations or local authority departments;

- data collected by the Equality and Human Rights Commission (www.equalityhumanrights.com/pages/eocdrccre.aspx);

- surveys conducted by ethnic minority community organisations;

- community development workers commissioned to carry out mapping surveys to identify stakeholders;

- university-led community engagement projects which provide local research data; and

- the IAPT Equality and Diversity Toolkit (www.nhs.uk/iapt/) for more information on gathering data about the local community.

3.2   Local third sector groups or organisations can make an important contribution to this process. They often have a good understanding of the needs of the local people in their area when they are the first point of contact for individuals from minority ethnic communities or hard-to-reach groups.

Particular issues for different groups

Black and minority ethnic (BME) communities

3.3   People from BME communities tend to have poorer health, shorter life expectancy and more difficulty accessing healthcare than the majority population.[5]

3.4   The Mental Health National Service Framework[6] states unequivocally that service users can expect services to be non-discriminatory. Additionally, the Race Relations (Amendment) Act 2000[7] imposes a legal duty on all public authorities actively to promote race equality.

3.5   Ensuring that access to psychological therapies is not hindered by people's ethnicity, culture or faith is one of the key priorities for the *Delivering Race Equality in Mental Health Care* action plan.[8] BME access to, and experience of, psychological therapies will be assessed in the central monitoring of both the IAPT and delivering race equality programmes. The action plan explains the context and the need for positive action, and the work generated by the plan has helped to identify examples of best practice described in this document.

Older people

3.6   As the number of people over the age of 65 increases, Age Concern estimates that the number of these people experiencing mental health problems will also rise by perhaps a third over the next 15 years.

3.7   Mental health problems in later life can have a considerable social impact, resulting in poor quality of life, isolation and exclusion. However, evidence-based psychological therapies can be effective for older people.

---

5   National Institute for Mental Health in England (2003) *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England*. London: Department of Health.

6   Department of Health (1999) *National Service Framework for Mental Health: Modern Standards and Service Models*. London: Department of Health.

7   Race Relations (Amendment) Act 2000. London: The Stationery Office.

8   Department of Health (2005) *Delivering Race Equality in Mental Health Care: An Action Plan for Reform Inside and Outside Services* and *The Government's response to the independent inquiry into the death of David Bennett.* London: Department of Health.

People with medically unexplained physical symptoms

3.8   Medically unexplained physical symptoms are physical symptoms that have no currently known pathological cause. They are a clinically, conceptually and emotionally difficult area to tackle. Clinical presentations vary greatly, from people who regularly attend GP surgeries with minor symptoms to people with chronic fatigue who are bed bound. The vast majority of medically unexplained physical symptoms, such as pain, irritable bowel syndrome and chronic fatigue syndrome, have no obvious cause and, after assessment, may or may not require input from health services.

3.9   However, studies have shown that between 20% and 30% of consultations in primary care are with people who are experiencing medically unexplained physical symptoms and have no clear diagnosis. It is estimated that this rises to an average of 52%[9] in secondary care, where a substantial proportion of secondary care resources are used by frequent attenders whose symptoms remain unexplained.

3.10   Evidence suggests that as many as 70% of people with medically unexplained physical symptoms also suffer from depression and anxiety disorders. People experiencing five or more medically unexplained physical symptoms have a considerably worse quality of life than people with a medical diagnosis for their symptoms. Those experiencing medically unexplained physical symptoms have been found to have:

- 50% more consultations;

- 50% more healthcare costs; and

- 33% more hospital admissions.

People with long-term conditions

3.11   Chronic physical illness can have a life-changing effect on a person's well-being and quality of life. The conditions involved include:

- cardiovascular disease;

- diabetes;

- chronic obstructive pulmonary disease;

- chronic pain;

---

9   Nimnuan C, Hotopf M and Wessely S (2001) Medically unexplained symptoms: an epidemiological study in seven specialities, *Journal of Psychosomatic Research*, 51: 361–7.

- sickle cell disease;

- rheumatoid arthritis; and

- stroke.

3.12   Depression and anxiety (as either a cause or a consequence of the physical illness), co-existing with a long-term condition, may exacerbate the perceived severity of the physical symptoms, reduce physical functionality, add to the person's distress, and increase health costs.

People with perinatal mental health issues

3.13   Pregnancy and the period after childbirth can bring a range of emotional changes for the mother, her partner and other members of the family. Many mothers find these changes a positive experience but some undergo emotional upheaval that can result in mental health problems. This is also a time for preventative perinatal interventions that promote strong attachment (between the parents and their baby, and the baby and other family members) and positive parenting, and thus reduce later mental health problems for parents or children.

3.14   The most common perinatal mental health problem is postnatal depression. Between 10% and 15% of women have postnatal depression in the first year after birth.[10] Many research studies have identified profound effects on relationships, families and children and are linked to:

- higher rates of depression in partners;

- higher levels of divorce;

- lower levels of cognitive development in children;

- lower levels of emotional security in children;

- higher levels of behavioural problems in children; and

- higher levels of psychological disorders in children.

Offenders

3.15   Offenders and their families represent one of the most socially excluded groups in our society. They have some of the highest levels

---

10 Department of Health and Department for Education and Skills (2004) *National Service Framework for Children, Young People and Maternity Services*. London: The Stationery Office.

of morbidity in terms of both physical and mental health problems. More than half the offenders in prison experience common mental health problems, such as depression and anxiety, very often linked to issues such as a history of family poverty, family breakdown and substance misuse.

3.16 Offenders often experience significant problems in gaining access to adequate health and social care services, adding to their problems of social exclusion and putting them at greater risk of continued offending.

Veterans

3.17 The most obvious risk to the mental health of service personnel is the violent and often distressing experience of combat. Other risks are:

- the strain of multiple or recurrent mobilisations;

- making the transition from service to civilian life; or

- consequences of the heavy drinking culture often found among service personnel.

People with learning disabilities

3.18 People with learning disabilities can experience the full range of mental health problems but it can be difficult to identify the prevalence of depression and anxiety disorders, as many of them are not able to express their feelings easily in words. This can mask the clinical presentation of a mental health problem and make an accurate diagnosis difficult. Nevertheless, many people with a mild learning disability can benefit significantly from psychological interventions.

Children and young people

3.19 Appropriate child and adolescent mental health services (CAMHS) should be available and accessible to all young people up to the age of 18. There should be clearly defined transition arrangements for young people needing to move on to adult services.

3.20 Those planning, commissioning and providing mental health services for young people have an important responsibility for the long-term life chances of those at risk of, or already experiencing, difficulties and distress. Most mental ill-health first manifests itself during childhood, which is also the time when fundamental familial, social and educational risk factors contributing to poor mental health arise.

4 Removing barriers to access

4.1   Social isolation can prevent people from accessing psychological therapy services. Three other factors with important potential to affect access to psychological therapy services have also been identified by the SIGs. These are the views, attitudes and behaviour of:

- the person experiencing common mental health problems, who would benefit from a psychological intervention;

- primary care professionals; and

- people working in specialist mental health services.

4.2   Some of the common barriers to access are described below. There are particular additional barriers relevant to specific groups. These are explored in more detail in the IAPT Positive Practice Guides relating to each group, which accompany this document (www.nhs.uk/iapt).

4.3   **People's own views, behaviours and attitudes** may prevent them from receiving psychological therapies, if they:

- believe mental health problems are shameful and should be hidden from everyone, including GPs, health professionals, or people in a position to help or provide information;

- have physical health problems or chronic pain that distract them (and the GP) from recognising the co-morbid mental health problem;

- use language to express their problems that fails to communicate the seriousness of those problems;

- have a fatalistic attitude that mental health problems are the result of previous wrongdoings or are preordained, and conclude that they have to deal with the consequences alone;

- wish not to 'cause a fuss', by bothering a busy GP or burdening other people with their problems;

- self-medicate with alcohol (particularly men) and mask their moods or problems, stopping them from being detected; or

- feel too hopeless to ask for help because they are depressed or anxious.

4.4 **General practitioners** (GPs) and other primary care professionals may inadvertently prevent people from accessing psychological therapies services, because they may:

- have time constraints in their surgeries that prevent them from diagnosing mental health problems effectively;

- recognise symptoms of depression or anxiety but fail to realise that they can be treated with psychological therapies;

- attribute mental health problems to someone's reactions to physical health problems, such as diabetes, Parkinson's disease, arthritic pain, stroke, cardiac or thyroid disorders, and so do not consider them suitable for treatment;

- believe that treating physical health problems is a higher priority than treating mental health problems and do not refer patients to psychological therapy services;

- mistakenly believe that psychological therapies do not work or are not appropriate for certain members of the community. This is particularly the case for people from BME communities, older people, young men and people with a learning disability; or

- not have the skills to identify and manage common mental health problems.

4.5 **Specialist mental health services** may inadvertently prevent people from accessing services that provide psychological therapies because they:

- lack confidence in working with people from specific community groups, especially if they have physical health problems or social, economic or communication difficulties; or

- have concerns about their ability or skills to build a therapeutic relationship with these groups.

Particular issues for different groups

Black and minority ethnic (BME) communities

4.6 People from BME communities may face additional barriers involving ethnicity, culture, language or faith.

4.7   Along with other social factors, these barriers may affect the perception, availability, use and, potentially, the outcome of an IAPT service, so commissioners should ensure that IAPT services are established, developed and maintained in a way that caters for all ethnic minorities, with high-quality, culturally responsive and language-appropriate services delivered in locations accessible to ethnic minorities.

4.8   Non-English speaking people (including those who use British Sign Language as a first language) may not be able to communicate their needs effectively if an IAPT service lacks appropriate language skills, which could mean that proper and correct assessments may not be made.

4.9   Cultural and social differences may be a barrier for some ethnic communities accessing psychological therapies. The stigma or lack of understanding of mental health problems may be a prohibiting factor for some individuals. An example of this is the lack of a word that means 'depression' in certain languages, e.g. Punjabi, Urdu and Hindi. Moreover, some BME communities will have explanations of mental health problems based around their own cultural and religious beliefs, which will be in marked contrast to the Eurocentric models of psychological distress upon which IAPT treatments are founded.

4.10   Community isolation may be a barrier for individuals from the 'newer' influx of ethnic minorities, i.e. new European Union (EU) member states or emergent African communities. These individuals may have little or no understanding of the availability of services provided in this country and may become isolated from many statutory services, including the wider health services. Such problems can be exacerbated by issues relating to migration status, when mental health may not be seen as a priority.

4.11   A lack of understanding of psychological therapies may also be a barrier to accessing these services. Some cultures or community groups will have little or no understanding of what psychological therapies are and what is involved in receiving these services. Some individuals may be fearful of engaging with a service they do not fully understand.

4.12   People from some communities or faith groups may wish only to see a therapist from the same ethnic or religious background and some may wish only to see a therapist of the same gender as themselves.

Older people

4.13 Social isolation of older people can prevent them from accessing psychological therapies. The Health Survey for England (2005) Mental Health and Wellbeing for Older People showed evidence of considerable social isolation among older people in England, with 18% of older men and 11% of older women reporting a severe lack of social support from family and friends. Additionally, people over the age of 80 were more likely to:

- have low incomes;

- live in poor housing;

- have little contact with friends;

- experience fear of crime;

- have difficulty in accessing important services; and

- have unmet transport needs, preventing them from participating in physical and leisure activities.

4.14 Some GPs mistakenly believe that feeling low is 'just part of getting older' and consider depression and/or anxiety to be an inevitable consequence of ageing. Some GPs fail to realise further investigation is needed or the value of treating mental health problems in older people.

4.15 Some GPs mistakenly believe that psychological therapies do not work, or are not available, for older people.

People with medically unexplained physical symptoms and long-term conditions

4.16 GPs and other healthcare professionals may also inadvertently prevent people who are experiencing medically unexplained physical symptoms or long-term conditions from accessing psychological therapies. GPs and other health professionals may believe that:

- mental health problems may be attributed to the person's reactions to their medically unexplained physical symptoms or long-term condition, and may consider the patient unsuitable for treatment; and

- identifying, investigating and treating any physical health problems are a higher priority than treating mental health problems.

4.17 People experiencing medically unexplained physical symptoms and long-term conditions may not receive psychological therapies because they may:

- believe they have physical health problems only and do not recognise that they are suffering from depression or anxiety disorders at all;

- not understand the impact that depression and/or anxiety can have on medically unexplained physical symptoms or long-term conditions;

- not understand the links between medically unexplained physical symptoms or long-term conditions and depression and anxiety disorders;

- have physical health problems or chronic pain that distract them (and the GP) from any mental health problems; and

- have physical health problems that restrict their ability to get to psychological therapy services.

People with perinatal mental health issues

4.18 An additional barrier in the perinatal period (during pregnancy, childbirth and the postnatal year) is the mother's (and/or her partner's) fear that mental health diagnoses will invite investigation by child protection services and possibly the removal of the infant from their care. These fears may increase the anxiety and prevent them from discussing or acknowledging any mental health problems they may be facing.

4.19 A pregnant woman or a new mother breastfeeding her baby may be reluctant to discuss or disclose her mental health problems in case medication is prescribed that has side effects on the baby.

4.20 The attitudes of service providers and other health professionals may also be a barrier, if they do not understand the significance of the mother's (and/or father's) mental health in relation to the child's development, attachment and mental health status, because they will fail to recognise perinatal mental health problems and then fail to make appropriate referrals to IAPT services.

Offenders

4.21 The main barrier is that these services are not available or offered to offenders. Frequent changes of location among offenders on remand or serving short sentences mean that any treatment they may have

been receiving before their imprisonment may not be continued to the same standard – if at all – in prison. Similarly, those offered treatment in prison are often not offered a continued service on their release into the community, and this may contribute to the likelihood of the individual re-offending.

4.22   In some prisons, mental health care may be commissioned using general prevalence studies, rather than a local needs assessment that takes account of the higher prevalence of mental health problems among offenders.

4.23   Offenders living in the community are often not given access to psychological therapies because of organisational or professional boundaries. Many health professionals working in the community do not believe they have the necessary skills to deal with the needs of offenders and are therefore not willing to offer treatment.

4.24   Given the complexity of both the physical and mental health needs of offenders, it will be important that IAPT services are aware of the importance of assessing particular aspects of complexity (e.g. personality disorder and psychosis) within these groups, prior to routine entry into the service.

4.25   Offenders' beliefs and behaviours may prevent them from receiving psychological therapies, including:

- fearing they may serve longer sentences for having mental health problems;

- having difficulty accessing general services such as GP surgeries in the first place (especially relevant for offenders serving community sentences); and

- fearing statutory services and not wishing to engage with professionals.

Veterans

4.26   Veterans' own views and attitudes may prevent them from receiving psychological therapies. They may:

- believe that NHS health professionals do not understand their service experience;

- be unwilling to go to the NHS for support; and

- fail to seek services provided by the Ministry of Defence because of disenchantment with the military culture.

People with learning disabilities

4.27 Challenging behaviour may prevent people with learning disabilities from accessing psychological therapies services. Reid (1995)[11] estimated that 15% of adults with severe learning disabilities have a severe associated behavioural disorder, either as a direct result of their disability or because of underlying psychiatric problems. People with learning disabilities are not always able to express their feelings in words and may use their behaviour or actions to express themselves. Their actions may be considered challenging, and the need for a referral to assess underlying causes is often not identified or supported.

4.28 GPs and other primary care professionals may also prevent people with learning disabilities accessing psychological therapies services. GPs and other primary care professionals may:

- not be aware of specially adapted assessments available to support diagnosis of mental health problems in people with learning disabilities;

- mistakenly believe the symptoms of depression or anxiety are merely 'difficult' or 'challenging' behavioural problems;

- not be aware that many people with mild learning disabilities have been shown to benefit from psychological interventions; and

- not have the skills to identify and manage mental health problems in people with learning disabilities.

4.29 Specialist mental health services may prevent people with learning disabilities from accessing services that provide psychological therapies because they:

- lack confidence in working with people with learning disabilities;

- have concerns about their ability to build a therapeutic relationship with people with learning disabilities;

- consider psychological therapies would be better used on other people with greater cognitive abilities; or

- fear for the vulnerability of a person with learning disabilities in a specialist or acute mental health environment.

---

11 Reid H. Psychiatric services for people with learning disabilities. *BMJ* 1995; 310: 1549–1550.

Children and young people

4.30 We know that socially excluded young people from the following groups have in the past found it difficult to access CAMHS:

- those from BME groups;

- those who are looked after or who have learning difficulties or caring responsibilities;

- those who are excluded from school; and

- young people in the 'transition' years, i.e. aged between 16 and 17.

4.31 These young people may present a complex array of social and mental health needs that require a holistic and flexible service response. They have high levels of need for mental health support and may also have particular worries about the stigma of approaching mental health services.

4.32 GPs and other primary care professionals sometimes prevent young people from accessing psychological therapies services because they:

- take the view that psychological therapies do not work for younger people;

- prioritise referring adults with depression and anxiety to psychological therapies services; and

- may not have therapists in primary care with appropriate training or experience to address the needs of young people.

5 Engaging with different communities

5.1 All the SIGs recognised the importance of proper and effective engagement with individuals from different community groups, to ensure that IAPT services meet their needs.

5.2 It is often much easier to consult individuals, voluntary or community groups and organisations that are already known. Investing time and effort in engaging with specific communities that have previously had limited contact may be more challenging. However, there are ways of reaching most groups in the community, although some may require additional support in order to engage. Commissioners may need to talk to the target group about the best way to consult and involve them.

5.3 Consideration may be given to using people who have existing expertise in working with particular groups, such as **voluntary or community organisations**. Such groups may act effectively as intermediaries by:

- providing commissioners with information that helps to engage the target group;

- raising awareness and signposting individuals to IAPT services (by being included in the referral pathway to IAPT services); and

- providing commissioners with useful feedback to help IAPT services improve the way they encourage engagement.

5.4 Commissioners will want to ensure that the location of IAPT services encourages engagement. A location that offers some form of anonymity would help to engage people who fear the stigma of having mental health problems, or who feel isolated from – or anxious about using – statutory services.

5.5 Positive engagement with local community groups can be encouraged by taking steps to ensure that IAPT service staff are representative of the local community. IAPT service staff with a similar background or understanding of the specific needs of a particular group will help to engage the target community group.

5.6 Some groups in the community will present specific challenges. All of the SIGs identified particular issues that commissioners should take into consideration when trying to engage with a target group.

Particular issues for different groups

5.7 Further information on engaging specific groups can be found in the Positive Practice Guides, available on the IAPT website (www.nhs.uk/iapt). The IAPT Equality and Diversity Toolkit also describes practical methods that commissioners can use to ensure that engagement is effective.

People from black and minority ethnic (BME) communities

5.8 Making good links and working collaboratively with faith groups is important, to ensure positive engagement with some community groups. Faith groups are often the first point of contact for individuals from some ethnic communities or hard-to-reach groups.

5.9 Commissioners should, if possible, develop links with service providers with specialist cultural and linguistic knowledge, or, where none exists, have access to qualified translators and interpreter services that can be used for individuals who speak little or no English.

5.10 Language-appropriate services that enable the correct assessment of individuals in a supportive environment are essential to engage non-English speaking groups. Translated reading material about IAPT services will also raise awareness of the service and promote the use of interpreters and translators within the service. It is also essential to consider translating self-help materials and computer software into languages other than English.

5.11 Providing the opportunity for self-referral to IAPT services is likely to be a particularly important way of providing equitable access for BME communities. One of IAPT's two national demonstration pilot sites, Newham, showed that opening up the opportunity for self-referral was particularly helpful. In particular, the proportion of different BME groups in self-referrals closely followed their rates in the community, whereas referral by GPs was less balanced.

Older people

5.12 Commissioners should recognise the important role of carers, social workers, and home care or care home staff in ensuring positive engagement with older people. They can identify older people with

mental health problems and be a key referral pathway into the IAPT service.

Medically unexplained physical symptoms and long-term conditions

5.13   GPs have an important role in ensuring that people experiencing medically unexplained physical symptoms or long-term conditions engage with IAPT services. GPs are usually the first point of contact for these people, and they may need to prepare patients for psychological therapies by explaining how depression or anxiety disorders may be linked to their physical health problems. Commissioners should ensure that GPs are engaged in the IAPT service and understand the benefits of referring their patients to it.

5.14   Many people are willing to accept that depression and anxiety disorders are linked to their medically unexplained psychological symptoms or long-term condition as long as they believe that their health professionals are willing to keep an open mind about the cause of any further physical symptoms. As many patients believe their symptoms are entirely physical problems, locating an IAPT service alongside a physical health framework may encourage engagement, e.g. in pain clinics or as part of a clinical assessment service or an intermediate clinical assessment team for musculoskeletal problems. IAPT services located in physical health services help to ensure that people's physical and mental health problems are addressed simultaneously.

5.15   Health professionals working with people experiencing long-term conditions, such as specialist respiratory nurses or diabetes specialists, may be well placed to identify the existence of depression and anxiety, and could provide an important referral route to the IAPT service while any physical health needs are also being addressed. It is, therefore, particularly important for IAPT services to engage their interest.

People with perinatal mental health issues

5.16   Commissioners should ensure that IAPT services take a flexible approach when providing effective psychological therapies for individuals (or families) with perinatal mental health problems, in order to encourage positive engagement. Some mothers (or fathers) may need:

- to bring their baby to the appointment;
- home visits (particularly when the baby is young);

- appointments at specific times or dates (to accommodate childcare arrangements for the baby or other children) or appointments to coincide with the baby's routine or carer availability, for example;

- longer sessions than others because of having to look after a baby simultaneously; and

- additional support from therapists or the presence of an additional carer to watch the child.

Offenders

5.17   Commissioners will need to ensure that IAPT services engage with offenders in a range of circumstances, including those in a prison setting, those living in the community and those who move in and out of prison settings and the community (i.e. those on remand or serving short sentences). Positive engagement can be encouraged by collaboration and co-operation between a range of services – different prisons, PCTs, NHS trusts, probation services, addiction services, women's centres. Excellent liaison with other services will be essential to meet the needs of offenders and promote engagement.

Veterans

5.18   The evidence is that veterans experience the same kind and quantity of mental health problems as the rest of the population. What sets them apart is a particularly strong cultural resistance to seeking help, especially when they believe that their military background will not be understood. IAPT staff awareness of veterans' needs and preferences is important in ensuring positive engagement with them.

People with learning disabilities

5.19   In designing how IAPT services will identify what people with learning disabilities like or do not like about them and how to adapt them in response, IAPT services should work collaboratively with organisations such as:

- specialist voluntary sector organisations;

- learning disability partnership boards;

- self-advocates;

- advocacy groups;

- local authorities; and

- specialist learning disability health services.

This will encourage engagement with people with learning disabilities.

Children and young people

5.20 IAPT services should reflect the needs and preferences of children and young people, if children and young people are to engage with the service. Commissioning services that are informed by, and are responsive to, the views of those using them, is central to government guidance underpinning delivery of public services. All recent major CAMHS policy emphasises the need to involve children and young people.

6 Training and developing the workforce

Background

6.1   It is an important principle that the IAPT workforce should reflect and be representative of the local community. The capacity and capability of therapists must be appropriate for the people they will be seeing.

6.2   Commissioners should understand their local population and demographic profile in order to commission an IAPT service with the appropriate number, skill mix and make-up of therapists.

General competencies

6.3   Detailed competencies, job descriptions and person specifications for the low- and high-intensity psychological therapist workforce are available in *A Practical Approach to Workforce Development* available on the IAPT website at www.nhs.uk/iapt.[12]

6.4   Low-intensity interventions are time limited and comprise guided self-help, computerised cognitive behavioural therapy (CBT), problem-solving, behavioural activation, brief CBT, medication compliance, signposting, and work on social inclusion and employment.

6.5   High-intensity interventions consist of evidence-based psychological therapies delivered typically in between 8 and 20 sessions. Initially this will include CBT but will be expanded to other evidence-based interventions (e.g. couples therapy, interpersonal therapy or some forms of counselling) as the programme rolls out.

6.6   IAPT national curricula[13] have been developed for training courses designed for low- and high-intensity therapy, and specifically require trainees to consider the unique needs of patients and their communities, and how their therapeutic approach should be individually tailored. In particular, trainees need to be sensitive to age, culture, disability, ethnicity, gender, language, religion and spirituality, and sexuality. Knowledge of relevant legislation and government policies is also required.

---

12 These documents are for therapists working with adults only.

13 National curricula are for therapists training to work with adults only (see www.nhs.uk/iapt).

6.7   Commissioners should ensure that each therapist has access to adequate supervision by appropriately trained and experienced therapists. A supervision competence framework has been developed and is available at www.nhs.uk/iapt. Further guidance on the importance of supervision for IAPT services is available at www.ucl.ac.uk/clinical-psychology/CORE/core_homepage.htm. A brief guide to supervision requirements for IAPT services is also available at www.nhs.uk/iapt.

6.8   Commissioners will need to monitor the competencies of therapists in order to ensure that the workforce has the key skills and capabilities required for the local population.

General principles for working with the whole community

6.9   It is important that the workforce that delivers IAPT services thoroughly understands the potential barriers that can prevent local people from accessing psychological therapies – such as gender, social exclusion, stigma associated with mental health problems, language and literacy – and are sensitive to people facing such barriers.

6.10   Therapists need to be able to engage with the local community and should help to break down such barriers. All therapists should be aware of how to enhance access for people in the local community. The use of self-referral to IAPT services should be encouraged, as it has been seen to be particularly effective in engaging hard-to-reach communities with the service. Fears that self-referral would 'open the floodgates' and overwhelm IAPT services have been shown to be unfounded.

6.11   Commissioners and IAPT services need to ensure that referrers, in particular, understand that **the whole community can benefit** from access to psychological therapies, particularly groups that may have been excluded in the past, such as older people, people from BME communities, people with a disability, children and young people.

6.12   Commissioners should ensure that all therapists thoroughly understand the effects of and interaction between co-morbid physical health problems and depression and anxiety. All therapists should understand that many people with depression or anxiety will also present with long-term conditions (such as diabetes), which may be both a cause and a consequence of their mental health problems. Many people with medically unexplained physical symptoms will have a psychological element which may or may not be understood or accepted by them.

6.13   Similarly, service leads and clinical supervisors should ensure that therapists are aware of the complexity of some people's psychological problems (e.g. personality disorder, psychoses, substance misuse, trauma, violence and abuse) and, where appropriate, be able to identify complex needs and associated risks before seeking advice or referring on to an appropriate specialist service.

6.14   All therapists should also be familiar with the wider healthcare community and be able to make referrals to other specialist services as and when required. Good links to other services in the locality will also increase referrals into the IAPT service. Therapists must have good knowledge of other care pathways so that their patients each receive a holistic care package.

6.15   This organisational knowledge is particularly important when therapists lack the skills or experience to deal with specific issues that need to be referred to specialists. Particular problems might occur at the interfaces between IAPT and secondary mental health care (e.g. severe mental health and personality disorders), specialist medical care (e.g. coronary heart disease and diabetes) and other specialist services (e.g. head injury, perinatal care and older people's care).

6.16   Commissioners should be satisfied that service providers are taking steps to ensure that the therapy workforce is culturally aware and sensitive to the specific needs of individuals from different cultures and backgrounds, and to the needs of those with different religions and beliefs. They should ensure that all therapists have the skills and capabilities to work with such cultural diversity. Therapists should also be aware that, in some cases, engagement may only be possible through a referral to another therapist who is of the same background, culture or faith as the patient.

6.17   Some individuals wanting to access an IAPT service will not have English as a first language (e.g. those who use sign language, or those who do not understand or speak English) or may face literacy problems. Commissioners will want to ensure that these language barriers can be overcome so that therapists can provide an effective and appropriate service. This is particularly important for the provision of written materials for self-help and computerised CBT that will be made available through low-intensity interventions. As a last resort, a translator may be required and commissioners may want to ensure that training is provided on working with translators so that a therapeutic relationship can be maintained and quality of care is not lost.

6.18   The provision of translators and associated training for translators and therapists will require adequate funding. It is not normally acceptable for family members to fulfil a translator's role in psychological therapies.

6.19   Recruiting low- and high-intensity therapists from minority groups should be encouraged. In some instances, it might be beneficial to encourage translators to train as therapists, if they have a suitable background. Specialist training for therapists (e.g. British Sign Language courses) should also be considered and funded. This may need to be led by a single PCT with a strategic health authority training commissioner.

6.20   Commissioners should ensure that the workforce understands life span development and the differing needs of people from various age groups. The skills and competencies needed by a therapist working with a 16-year-old will be significantly different from those of someone working with an 85-year-old. It is also vital that there are clear pathways at the interface of services, for instance for children and young people.

6.21   Commissioners may want providers to ensure that trainee therapists are given broad experience of working with a range of age groups, including older people who will have a number of different needs. Specialist supervision groups for specific aspects of practice might also be considered during training and also for qualified staff.

Specialist knowledge and skills

6.22   Commissioners may wish to ensure that therapists have additional skills that reflect the needs of the local population and are relevant to their local community.

6.23   Commissioners wishing to ensure that the needs of **offenders** are adequately met in their local areas should ensure that therapists understand their specific needs (including those within the community, those in prison settings and those who frequently move between prison and the community). Therapists may need additional training on risk and safety issues and require additional supervision when working in a prison setting. Co-morbidity, dual diagnosis and literacy problems are particularly relevant.

6.24   **Veterans** are a population that reflect the general population in terms of age and need. However, commissioners should ensure that therapists understand military culture. The general misconceptions

often held about (and held by) veterans should be understood by therapists and challenged. Issues of substance misuse, gender and the stigma some people associate with having mental health problems may be particularly relevant.

6.25 Commissioners developing **perinatal** IAPT services should ensure that therapists understand the (sometimes highly specialised) needs of expectant and new mothers, fathers and the infant. Commissioners should ensure that therapists are able to identify and respond to violence and abuse, and have training in safeguarding issues and child protection processes. Therapists should understand that referrals for those with perinatal mental health problems must often be made quickly to ensure the safety of both adult and infant. Low-intensity interventions for this group may already be delivered by other staff, such as midwives and health visitors, who have received or may require further specific training in psychological awareness and approaches.

6.26 Commissioners have a duty to ensure that services are equally accessible to people with **learning disability or cognitive impairment** and will want to ensure that therapists are able to provide the level of care that is required to those with additional needs.

6.27 Commissioners should require therapists working with **older people** to understand the diversity of older people (e.g. in terms of race), ageism in society and its potential impact on accessibility to psychological therapy services. Therapists should have familiarity with policy frameworks and good practice guides to older people's services and care pathways, knowledge of normal and abnormal ageing, age-specific assessments and outcome measures, and adjusting therapy to cognitive and physical impairments, and awareness of elder abuse, needs of carers, neglect, self-harm and risk of suicide in later life.

6.28 Commissioners should ensure that staff working with **children and young people** have the necessary psychological awareness at primary care/tier-one level and that specialist workers have the relevant evidence-based competencies and supervision, and that there are relevant local training arrangements in place.

6.29 Children's and young people's psychological wellbeing and mental health services (universal, targeted and specialist services) are delivered by a network of agencies comprising a workforce from all sectors (health, social care, education and voluntary) and from across the whole range of professional disciplines. Collaborative commissioning arrangements should ensure that services are

available locally. They are also crucial to effective service provision to children and young people. Commissioners should consider how these networks can help to ensure that learning and development opportunities for the workforce can be developed at a more strategic level across all disciplines and agencies. Commissioners should ensure the development of a multi-disciplinary workforce, which is appropriately skilled, experienced, confident and competent at each of the levels of service provision across the care pathway, and encourage the development of skills to achieve a psychologically aware workforce.

6.30   Adult and children's mental health services should collaborate to improve care for young people who are moving from children's to adults' services, including help for their families. This should involve Workforce Development Directorates working alongside those who are developing and delivering service specifications to ensure that education commissioning also meets current and predicted need. The formation and strengthening of partnerships or working alliances with service providers can help promote cross-sectoral approaches to education and training.

6.31   Commissioners should ensure that IAPT services are delivered in a person-centred and culturally sensitive manner. Those delivering services and therapists should be aware of the broad range of diverse but specific barriers and needs relating to psychological treatments for people from **BME communities** and ways of addressing them. All therapists should have received appropriate values-based and delivering race equality training. In addition, IAPT training courses should specifically cover culture sensitivity and the delivery of psychological therapies. Additional resources may be required to translate therapeutic materials into different languages and to ensure that self-help materials are available in a wide range of formats including computerised resources, books and leaflets, and audio-tapes and DVDs for those with literacy problems.

6.32   Commissioners of services appropriate for people with **long-term conditions and medically unexplained physical symptoms** need to communicate with commissioners of specialist medical services, such as commissioners of diabetes services and hospital-based liaison services. There may be an important role for psychological therapy services, including IAPT services, in the training of other NHS staff within more specialist services so that they are more psychologically aware and have knowledge of some of the elements of low-intensity interventions. In addition, specialist medical services may provide

training to therapists to raise awareness or increase knowledge of other medical conditions.

Implications for education and training

6.33   The importance of achieving the specialist knowledge described above is recognised in the commissioning of IAPT training courses for low- and high-intensity therapy workers. However, given that the curricula have been designed specifically with the assessment and therapeutic needs of adults of working age, additional training either within IAPT courses or following graduation may be required, depending on the needs of a specific service.

6.34   In order to supplement the existing IAPT curricula for low- and high-intensity therapy workers, we recommend the publication of IAPT Positive Practice Guides by the SIGs in order to provide additional specialist guidance and resources for both training courses and services. These guides would ensure that advice is provided about how to ensure that the needs of the following communities are met:

- BME communities;
- older people;
- people with medically unexplained physical symptoms;
- people with long-term conditions;
- people with perinatal mental health needs;
- offenders;
- veterans;
- people with learning disabilities; and
- children and young people.

6.35   Specific short courses may have to be considered for existing staff and for those staff working within an IAPT service that has a specialist remit (e.g. prisons or veterans). Such courses may have to be specially commissioned and funded.

6.36   Specialist advice and learning resources have been developed and identified by many professional bodies, charities and voluntary organisations working with these special groups.

7 Practice-based commissioning

Background

7.1   Practice-based commissioning (PBC) is about engaging GP practices and other primary care professionals in the commissioning of services. Through PBC, front-line clinicians are being provided with the resources and support to become more involved in commissioning decisions.

7.2   PBC will lead to high-quality services for patients in local settings. GPs, nurses and other primary care professionals are in a prime position to translate patients' needs into redesigned services that best deliver what local people want. More information about PBC is available on the Department of Health website.[14]

IAPT and PBC

7.3   A number of documents relating to IAPT have been developed to allow PBC clusters to develop an IAPT-compliant service. These documents will be available on a CD-ROM, which will be distributed through the Local Medical Committee networks. The content of the CD-ROM will be available on the IAPT website at www.nhs.uk/iapt.

7.4   The documents provided on the CD-ROM include:

- tools for commissioning;

- a draft business case;

- a financial modelling template;

- a medically unexplained physical symptoms tool to allow GP practices to estimate the number within their practice who are likely to have medically unexplained physical symptoms;

- the evidence base to the psychological links with long-term conditions and medically unexplained physical symptoms;

- information on effective interventions; and

---

14 www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Practice-basedcommissioning/index.htm

- information on workforce issues, and in particular a paper that describes new ways of working in primary care mental health.

7.5 The intention is that the information contained on the CD-ROM will provide details of what is needed for a PBC cluster to commission a locally sensitive, IAPT-compliant, accessible psychological therapy service.

8 Commissioning for outcomes

8.1 Routine outcome collection is fundamental for effective delivery of IAPT services. Services cannot be demonstrably effective in meeting people's needs unless health and social outcomes are recorded sessionally and accurately for each patient.

8.2 The ongoing management of patient outcomes will ensure that the right service is delivered to the right number of people at the right time and with the right results.

8.3 The primary purpose of measuring outcomes is to monitor the improvement in the person's experience and the benefits they have derived from the service. However, outcome measures can also be used by commissioners to monitor the overall service performance and can be useful in managing the performance of service providers, improving quality and ensuring that provider service-level agreements are delivering good value for money.

8.4 Another benefit of outcome measures for commissioners is that the outcomes they expect to see delivered by providers can be specified. This can be achieved by collaborating with providers on the clarification of commissioning expectations in advance of the tendering stage, through local provider forums where they exist, and including clear guidance in the service specification document.

8.5 The IAPT Outcomes Toolkit was published in July 2008 and identifies the minimum data set that all IAPT services are required to collect.[15] The Outcomes Toolkit contains further information on the benefits of routine outcome collection that may be helpful for commissioners.

8.6 This guidance clarifies how important it is for commissioners of IAPT services to work collaboratively with commissioners of other, related services to ensure cohesion between services. IAPT services commissioned jointly should aim to ensure that patient care pathways are integrated to other relevant services, maximising referral routes in and out of IAPT services, and ultimately ensure better outcomes for patients.

---

15 www.iapt.nhs.uk/2008/07/improving-access-to-psychological-therapies-iapt-outcomes-toolkit/

9 Acceptability of different treatment options

9.1   IAPT services should provide evidence-based psychological treatments recommended by NICE. However, within these parameters, it is important that individuals accessing the IAPT service have a choice of treatments appropriate for them. Some psychological therapies may not be as effective as others for use with a person from a particular background or age group or with particular beliefs. That said, it is encouraging that the Newham demonstration site found that CBT was equally effective in white, black and Asian populations.[16]

9.2   The rigorous collection of data is vital in building even better knowledge and understanding of specific therapies' effectiveness for individuals from different communities, cultural groups and age groups.

9.3   This gathering of evidence and outcome measures will enable future IAPT services to identify the most effective and appropriate psychological therapy for individuals from specific communities, with different beliefs, backgrounds and levels of understanding, and from a range of age groups.

---

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

10 Moving forward

10.1 As IAPT services roll out across England, commissioners have a duty to ensure that the services are available and appropriate to everyone in the local community, including individuals from hard-to-reach groups. In commissioning and designing IAPT services, commissioners should ensure that services adhere to relevant legislation and principles that eliminate unlawful or unjustifiable discrimination, promote equality of opportunity and meet other equality requirements of the equality duties.

10.2 Commissioners may find it helpful when commissioning and designing IAPT services to refer to specific IAPT Positive Practice Guides (www.nhs.uk/iapt) for additional information about how to ensure that the needs of the following communities are met:

- BME communities;
- older people;
- people with medically unexplained physical symptoms;
- people with long-term conditions;
- people with perinatal mental health issues;
- offenders;
- veterans;
- people with learning disabilities; and
- children and young people.

10.3 The IAPT Equalities Toolkit provides additional practical information that may be useful to commissioners in designing and commissioning IAPT services that are appropriate to meet the needs of the whole community.

10.4 The IAPT Equality Impact Assessment is available on the IAPT website (www.nhs.uk/iapt). It provides detailed information on anticipating and avoiding any discriminatory or negative consequences for a particular group, on the grounds of:

- race;

- gender;

- disability;

- faith;

- sexuality; or

- age.

10.5 Ensuring that all local IAPT services are subject to a rigorous Equality Impact Assessment is an important recommendation of the IAPT programme. As strategic health authorities work with their local PCTs to determine the expansion of this programme, a thorough Equality Impact Assessment of the local service is strongly encouraged.

Annex: Special interest groups members list

Black and Minority Ethnic (BME) Special Interest Group

Matt Fossey (Chair)	Department of Health (DH)/Care Services Improvement Partnership (CSIP)
Stephanie Gray	DH/CSIP
Marcel Vige	Mind
Prof. Swaran Singh	Warwick University
John Cowley	British Association for Counselling and Psychotherapy (BACP)
Brendan McLoughlin	London Development Centre, CSIP
Dele Olajide	South London and Maudsley NHS Foundation Trust
Narinder Gharial	Confederation of Indian Organisations
Asha Day	CSIP
Joe Mairura	CSIP
Adrian Webster	Head of Lambeth Psychology, South London and Maudsley NHS Foundation Trust
Deborah Cameron	Addaction
Amra Rao	Newham Psychological Therapies Service
Frank Keating	Royal Holloway, University of London
Prof. Kam Bhui	Queen Mary, University of London
Tracy Lee	Derbyshire County Primary Care Trust (PCT)
Faith Stafford	BACP
Georgina Horobin	Mental Health Commissioner, Derbyshire County PCT
Jim Fowles	Mental Health Delivering Race Equality Lead, DH
Sachdev Seyan	Hertfordshire Partnership NHS Foundation Trust
Dominic Glover	West London Mental Health Trust (MHT)

Shahana Ramsden	Deputy Director, Delivering Race Equality Programme, CSIP
Mpume Mpote	Black Wellness
Shahara Miah	Assistant Commissioning Manager, Mental Health, Ealing PCT
Ian Davis	Head of Integrated Commissioning, Ealing PCT/ London Borough of Ealing
Michael Lilley	Director, My Time
Stephen Maynard	Stephen Maynard and Associates
Marie Bradley	Consultant Practice Therapist, Common Mental Health Problem Service
Bev Stewart/Michelle Jones	Open Doors Forum
Christina Jassi	Community Development Worker, Bedfordshire and Luton Mental Health and Social Care Partnership Trust
Jonathan Isaacs	British Society for Mental Health and Deafness
Ross O'Brien	Community Development Worker, Barnet
Baljeet Ruprah-Shah	Head of Mental Health and Wellbeing Service, Ealing PCT
Jane Rosoman	Clinical Lead, Mental Health and Wellbeing Service, Ealing PCT
Mark Kenwright	Head of Cognitive Behavioural Therapy (CBT) Service, West London MHT

Older People Special Interest Group

Matt Fossey (Chair)	DH/CSIP
Stephanie Gray	DH/CSIP
Ann-Marie Nielsen	Buckinghamshire Pathfinder
Jeff Love	Stoke Pathfinder
Sharon Taafe	Stoke Pathfinder
Jane Garner	Royal College of Psychiatrists (RCPsych)
Sandra Evans	RCPsych
Caroline Williams	Sussex Partnership NHS Foundation Trust and South Thames PSIGE/DCP

Steve Boddington	South London and Maudsley NHS Foundation Trust
Sean Haldane	British Psychological Society (BPS)
Kate Mahony	BPS
Clare Crellin	Sussex Partnership NHS Foundation Trust
Elspeth Stirling	PSIGE, DCP
Nadine Schofield	CSIP
Mandy Rudd	Senior Nurse
Carolyn Chew-Graham	GP and Senior Lecturer, University of Manchester
Robert Baldwin	University of Manchester
KCM Wilson	University of Liverpool
A Hill	University of Salford
Lesley Carter	CSIP
Adrienne Little	South London and Maudsley NHS Foundation Trust/BPS
Philip Hurst	Age Concern England
Sube Banerjee	Institute of Psychiatry, King's College London
Tom Howell	CSIP
Toby Williamson	Mental Health Foundation
Debbie Clarke	Consultant in Clinical Psychology/Lead for Hertfordshire Older Adults Special Interest Group
Rachel Glynn-Williams	Chartered Psychologist
Amanda Gatherer	Clinical Psychologist, Coventry and Warwickshire Partnership NHS Trust
Gillian Russell	DH
Jason Hepple	United Kingdom Council for Psychotherapy (UKCP)
Gwyn Higginson	Cognitive Behavioural Psychotherapist/ Co-facilitator, British Association for Behavioural and Cognitive Psychotherapies (BABCP)

Long-Term Conditions (LTC) and Medically Unexplained Symptoms (MUS) Special Interest Group

John Hague (Chair)	Sainsbury Centre for Mental Health (SCMH)
Matt Fossey	DH/CSIP
Stephanie Gray	DH/CSIP
Frank Holloway	Institute of Psychiatry, King's College London
Claire Hallas	Health Psychology Lead, Royal Brompton and Harefield NHS Trust
Nikki Oatham	Psychology Lead, Kent and Medway NHS and Social Care Partnership Trust
Tracy Morton	DH
Elspeth Guthrie	University of Manchester/RCPsych
Prof. Christopher Dowrick	University of Liverpool
Wendy Clarke	University of Manchester
Dr Richard Byng	Peninsula Medical School
John Cape	Head of Psychology, Camden and Islington Mental Health and Social Care Trust
Jeremy Clarke	New Savoy Partnership
Prof. Paul Salkovskis	Institute of Psychiatry, King's College London
Prof. Richard Morriss	University of Nottingham
Linda Gask	University of Manchester
Louise Robinson	BACP
Steven Mackie	BACP
Edward Greenwood	Rethink
Phil McEvoy	Salford PCT
Sylvain Laxade	Salford PCT
Judith Sheehan	North Tees and Hartlepool PCT
Suzanne Withington	Stoke PCT
Hazel Thorp	Dorset PCT
Alan Cohen	CSIP Primary Care Lead, SCMH
Tom Dodd	Primary Care and Dual Diagnosis, CSIP
Alex King	BPS Faculty of Clinical Health Psychology

Hilary Rankin	BPS Faculty of Clinical Health Psychology
John Larsen	Head of Evaluation, Rethink
Dr Nicky Veronica Thomas	Consultant Health Psychologist, Guy's and St Thomas' NHS Foundation Trust
Prof. Michael Chester	Consultant Cardiologist and Director, National Refractory Angina Centre
Phillip Kinsella	CBT Therapist, Queen's Medical Centre, Nottingham
Caroline Maxted	Research Assistant Psychologist, MUS Project, Plymouth
Andrew Nicholls	Hertfordshire Partnership NHS Foundation Trust
Chris Powell	UKCP
Rupert Noad	Clinical Neuropsychologist, MUS Project, Plymouth

Offenders Special Interest Group

Matt Fossey (Chair)	DH/CSIP
Stephanie Gray	DH/CSIP
Lorraine Khan	SCMH Youth Offender Project
Dave Knight	DH Offender Health
Kerry Manson	Consultant Clinical Psychologist, HM Prison Liverpool
Elizabeth Tysoe	HM Inspectorate of Prisons
Louise Falshaw	HM Inspectorate of Prisons
Nicholas Pascoe	HM Prison Service
Brian Docherty	HM Prison Service
Richard Bradshaw	DH Offender Health
Ruth Shakespeare	Public Health Team, Government Office South West
Lynn Emslie	CSIP
Anne Richardson/ Mignon French	DH Offender Health
Simon Coombes	Dorset Pathfinder
Jo Bailey	National Offender Management Service (NOMS)

Graham Durcan	SCMH Criminal Justice Programme
Charlie Brooker	University of Lincoln
Gwen Adshead	West London MHT
Mark Westacott	Consultant Clinical Psychologist, Prior Consulting

Veterans Special Interest Group

Bob McDonald (Chair)	Senior Mental Health Policy Lead, DH
Matt Fossey	DH/CSIP
Stephanie Gray	DH/CSIP
Richard Williams	Adviser on Emergency Preparedness
John Hall/Ian Allred	Health and Social Care Advisory Service (HASCAS)
Jonathan Iremonger/ Chris Williams	Ministry of Defence
Mary Robertson	Camden and Islington PCT
Jenny Priest	Policy Adviser, Royal British Legion
Dave Rutter	Stakeholder and Partner Relationships, DH
Dr Anne Braidwood	Ministry of Defence

Improving Access to Psychological Therapies (IAPT) Workforce Team

Roslyn Hope	Director
Graham Turpin	Associate Director
Ruth Duffy	Workforce Development Specialist
John Alcock	Associate Director

Children and Young People Special Interest Group

Matt Fossey (Chair)	DH/CSIP
Stephanie Gray	DH/CSIP
Jenny Hunt	Chair, Children and Young People, BPS
Paul Stallard	University of Bath
Ruth Armstrong	BPS/Newham Child and Family Consultation Service
Avis Johns	Young Minds
Susan Pattison	University of Newcastle/BACP

Andrew Hill	University of Salford
Irene Sinclare	South London and Maudsley NHS Foundation Trust/BPS
Mary John	University of Surrey
Maria Crowley	Sussex Partnership NHS Foundation Trust
Philip Dodgson	Sussex Partnership NHS Foundation Trust
Barry Nixon	Workforce Lead, Child and Adolescent Mental Health Services (CAMHS)
Sue Bailey	University of Central Lancashire
Rachel Calam	Child Psychologist, University of Manchester
Jonathan Green	University of Manchester
Karen Cromarty	BACP
Miranda Wolpert	University College London
Peter Jenkins	University of Salford
Helen Lambert	Bury PCT
Claire Maguire	Bury PCT
Elaine Bousfield	Kooth.com Project, Xenzone
Wendy Mcdonald	University of Manchester
Nicola Dummett	Children, Adolescents and Families Special Interest Branch, BABCP
Dawn Rees	CAMHS, CSIP
Carmel Richardson	Sussex Partnership NHS Foundation Trust
Ann York	CAMHS Adviser, DH
Denise Fisher	Liverpool John Moores University
Aileen Moore	Waller Trainer, Sheffield PCT
Bernadette Devine	Brighton IAPT Project Manager
Laura Donington	UKCP
Catherine Gallop	University of Exeter
Joanna Grave	Children, Adolescents and Families Special Interest Group, BABCP
Chip Chimera	Institute of Family Therapy
Anna Dalton	Bury PCT

Perinatal Special Interest Group

Matt Fossey (Chair)	DH/CSIP
Stephanie Gray	DH/CSIP
Jane Verity	Maternity Lead, DH
Margaret Oates	University of Nottingham/RCPsych
Pat Seber	BACP
Pauline Hall	Clinical Psychologist, Salford Pathfinder
Dr Suzanne Glendenning	Salford Psychology Services
Michelle Cree	Consultant Clinical Psychologist, Derby City General Hospital
David Goodban	CAMHS Regional Development Worker, CSIP
Prof. Steer	Imperial College London
Faye Macrory	Consultant Midwife, Manchester Specialist Midwifery Service
Jan Cubison	Sheffield Perinatal Mental Health Service
Helen Scholefield	Clinical Director and Consultant Obstetrician, Liverpool Women's NHS Foundation Trust
Janice Rigby	South London and Maudsley NHS Foundation Trust
PO Svanberg	Health-led Parenting Project
Carol Tiernan	Royal College of Midwives (RCM)
Angela Hulbert	RCM
Mervi Jokinen	RCM
Brid Kelly	Hertfordshire Partnership NHS Foundation Trust
Phil Mollon	Hertfordshire Partnership NHS Foundation Trust
Angelika Wieck	Consultant Psychiatrist, Manchester
Jane Hamilton	Perinatal Psychiatrist in Maternal Health
Marion Fantom	Specialist Midwife, Manchester
Mel Parr	Psychology Lead, Hertfordshire Pathfinder Site
Sarah Barratt	Assistant Psychologist, Salford
Marjorie Finnigan	Perinatal Mental Health Worker
Michael Lilley	Director, My Time
Pauline Slade	Clinical Psychologist, Sheffield
Suzanne Truttero	Midwifery Adviser, DH

Department of Health

recycle
When you have finished
with this please recycle it

50% recycled
This is printed on
50% recycled paper