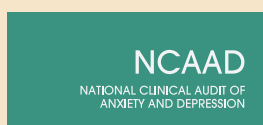# How are secondary care psychological therapy services for adults with anxiety and depression performing?

Results of an audit of NHS-funded services in England:
a co-produced report

CONTENTS

Cover image: 'Uncertain Reflections (reeds)' by Jessie Davies - winner of NCAAD art competition

"Where the reed stems enter the water, they disturb the calm reflections. Uncertainty grows as we look more closely, with multiple intrusions and distortions causing us to question our perceptions.

In the end, we seem to be viewing the scene as if we, ourselves, are under the water."

KEY FINDINGS AND RECOMMENDATIONS

The audit found that most adults who received psychological therapy rated their therapists highly and felt helped by the treatment they received, but access was poor with almost half of adults waiting over 18 weeks from referral to the start of treatment. Many service users also reported a lack of choice in key aspects of their therapy and outcome measures were not being routinely used to assess change.

Principal recommendation

All Mental Health Trusts should have a Trust-wide Psychological Therapies Management Committee. This will enable Trusts to co-ordinate different parts of psychological therapy provision, offering clear leadership, both professionally and managerially. This should include service user and carer representatives, the lead psychological professional for the Trust, direct representation at Board level and coordination of core tasks, including systematic data collection, waiting list management, outcome measures, service user involvement, care pathways, training and supervision.

THE PURPOSE OF THIS REPORT

This report presents the findings of the National Clinical Audit of Anxiety and Depression (NCAAD) focusing on the delivery of psychological therapies in secondary care adult mental health services. The audit was carried out by the Royal College of Psychiatrists (RCPsych) in partnership with the British Psychological Society (BPS) between 2018 and 2019.

This report is co-produced with input from service users and carers, clinical advisors, the NCAAD team and the McPin Foundation, an independent mental health research charity. It is designed to be accessible to anybody interested in mental health services and the provision of psychological therapy.

The main findings of the audit are presented along with recommendations and feedback from service users and carers. This report presents national data from services across England as related to the recommendations that have been made. Readers who are interested in how performance at different Trusts varies can access this information on the audit webpages under the Spotlight tab.

Jargon buster

Royal College of Psychiatrists (RCPsych)
This is a professional body that is responsible for setting and improving standards in psychiatry. They manage a programme of National Clinical Audits, which are commissioned by a body called the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.

The British Psychological Society (BPS)
This is the representative body for psychology and psychologists in the UK. It is made up of members from all walks of life, whose primary interest is in the development and application of psychology for the greater public good.

The society is responsible for the promotion of excellence and ethical practice in the science, education, and practical applications of psychology.

The McPin Foundation
This is a mental health research charity. They believe mental health research is done best when it involves people who have lived experience of the phenomenon being researched – in this case, people who have had psychological therapy or cared for those who have.

HOW WERE SERVICE USERS AND CARERS INVOLVED IN THE AUDIT?

People with personal experience of using secondary care psychological therapy services and those that support them were involved from the start of the audit. A Service User and Carer Reference Group helped to develop the tools used to measure service performance.

Once the audit had been conducted, a series of consultations were held with the Reference Group in collaboration with the McPin Foundation to discuss the findings. Service users and carers gave their responses to the results, and how they related to their own experiences, and suggested potential recommendations.

The RCPsych used this feedback and that provided by a Steering Group to draw up a list of final recommendations. These recommendations appear throughout the report and a full version can be found on page 32.

Quotes from the service user and carer consultations, as well as quotes from the service user survey, are included throughout the report.

Identifies quotes from the Service User and Carer Reference Group

Identifies quotes from the service user survey

Identifies topics that are priorities for service users and carers

Jargon buster

Service user
For the purposes of clarity, we have used the term 'service user' to describe people who use services to receive support for their own anxiety and/or depression. We acknowledge that people may have their own preferences or terms they identify with.

Carer
For the purposes of clarity, this describes family members, friends and other people who support or care for a loved one with anxiety and/or depression. We acknowledge that people may have their own preferences or terms they identify with.

INTRODUCTION

The aim of the National Clinical Audit of Anxiety and Depression (NCAAD) is to find out how services for adults with anxiety and depression are performing. Services are measured against criteria relating to the care and treatment they provide, so that the quality of care can be improved. NCAAD is a three-year improvement programme focusing on NHS-funded secondary care services provided to service users with anxiety and/or depression in England. It is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.

In our first report, we examined the quality of care that people received who were admitted to hospital for anxiety and depression. In this report, we take a closer look at another key aspect of NHS care for adults with anxiety and depression: the availability and quality of secondary care psychological therapy services. These included services delivered by specific identified psychological therapy staff integrated within multi-disciplinary teams and services delivered by specialist teams.

Anxiety and depression

Anxiety and depression are often referred to as 'common mental health problems'. In England, one in six adults have a diagnosis that includes one of the two and they often occur together.

Anxiety can be severe and long-lasting. It can be an extreme form of worry that triggers headaches, nausea, an irregular heartbeat, panic attacks, insomnia, feelings of being disconnected from your body or surroundings, and spirals of repetitive thoughts. These are just some of the symptoms that people can experience. Generalised anxiety disorder (GAD), social anxiety disorder (social phobia), post-traumatic stress disorder (PTSD), obsessive compulsive disorder (OCD), specific

Jargon buster

Healthcare Quality Improvement Partnership (HQIP)
This is an independent organisation that aims to improve health outcomes by enabling those who commission, deliver and receive healthcare to measure and improve healthcare services.

phobia, panic disorder and agoraphobia are all examples of diagnoses that people might receive depending on the particular anxiety-related difficulties that they are experiencing. Depression is also very common. It is estimated that about 70 per cent of adults with depression have mild depression, 20 per cent moderate and 10 per cent severe. The mental health charity, Mind, has a helpful description of this spectrum on its website. "In its mildest form, depression can mean just being in low spirits. It does not stop you leading your normal life but makes everything harder to do and seem less worthwhile. At its most severe, depression can be life-threatening because it can make you feel suicidal or simply give up the will to live."

Anxiety and depression often occur together, and can occur with other conditions that lead people to secondary care mental health services, such as psychosis, bipolar disorder and personality disorder.

Psychological therapies

There is strong evidence that psychological therapies are effective for a wide range of mental health problems, including anxiety and depression. Some types of psychological therapy are recommended by the National Institute for Health and Care Excellence (NICE). Cognitive behavioural therapy (CBT) is recommended for all anxiety disorders and a wider range of therapies are recommended for depression, including interpersonal therapy, CBT, counselling, behavioural couples therapy, behavioural activation and short-term psychodynamic therapy.

Despite how common they are, anxiety and depression frequently go unrecognised. There can also be difficulties accessing psychological therapy services, which means that many adults who might benefit from treatment do not receive it.

The Improving Access to Psychological Therapies (IAPT) programme was initially developed in 2008 to improve access to evidence-based psychological therapies in the NHS. Most adults who ask for help with anxiety or depression will be seen in an IAPT service, which is closely linked to primary care.

However, this is not suitable for everyone. Some people have more complex and severe difficulties that require help from secondary care mental health services such as community mental health teams, crisis and home treatment teams, secondary care psychology/psychotherapy services, specialist services and inpatient services.

Jargon buster

NHS England (NHSE)
NHS England leads the National Health Service in England and supports the NHS to deliver improved care for patients.

Primary Care
These are services that provide the first point of contact for healthcare. This will include general practice, community pharmacy, dental and optometry services.

Secondary Care
This is where people are usually referred to when they have a health problem that cannot be managed in primary care. Secondary care healthcare is delivered by health professionals with specialist knowledge.

NHS Trust
For the purposes of this report, this is a body that provides secondary care health services.

Inpatient Mental Health Services
This refers to a facility with hospital beds that provide 24-hour care for individuals experiencing severe mental illness. These units provide a range of treatment options which aim to help improve the mental wellbeing of patients, with a consultant psychiatrist or other professional acting as the responsible clinician. Inpatient mental health services are also able to care for people detained under the Mental Health Act.

Community Mental Health Services
These are services within secondary care which use diverse teams of mental health professionals to provide specialist care outside of a hospital environment. Community services include crisis teams, early intervention teams and assertive outreach teams.

NICE
This stands for the National Institute of Health and Care Excellence. It is a body that provides national guidance and advice to improve health and social care.

Audit development

This audit was informed by the results of a previous National Audit of Psychological Therapies (NAPT), which ran between 2010 and 2014. This looked at psychological therapy services in both primary and secondary care and identified a number of areas for improvement. After a review of its findings and recommendations, a decision was made to focus the audit on psychological therapy delivered within secondary care. This was because detailed information on the quality of care delivered through the IAPT programme is regularly published (see https://digital.nhs.uk/), but there are no comparable data for people accessing psychological therapy in secondary care adult mental health services.

All secondary care psychological therapy services were encouraged to participate in this audit. The performance of these services was measured against eight standards, covering access to therapy, the type of psychological therapy provided, service user experience and satisfaction, and therapist training and supervision. The standards provide a framework of best practice for psychological therapy services. They give service users and carers an idea of the sort of care they should expect from a service and tell service providers what they need to do to provide high quality care. They were based on national guidance, with input from an expert Steering Group and a Service User and Carer Reference Group.

This audit aims to improve access, appropriateness, satisfaction and outcomes of psychological treatment in secondary care. By benchmarking how Trusts are performing locally in comparison to national results, the audit can support services to develop local improvements. It is hoped that, as a result, service users will feel encouraged and confident in the psychological care they receive from NHS Mental Health Trusts across England.

A list of NICE-recommended psychological interventions can be found on page 40.

For sources of support for your own mental health or that of a loved one, please see page 41.

THE STANDARDS

The standards are a way to measure how well a mental health service is performing

ACCESS AND WAITING TIMES

1. The service routinely collects data to assess equity of access.

    Guidance: This includes age, gender, ethnicity, employment and accommodation status.

2. A person who is assessed as requiring psychological therapy does not wait longer than 18 weeks from the time at which the initial referral is received to the time that treatment starts.

APPROPRIATENESS OF THERAPY

3. Psychological therapies are provided in line with relevant NICE guidance (type and number of sessions) for the service user's diagnosis/condition.

SERVICE USER INVOLVEMENT

4. Service users report being provided with information and choice about their treatment.

5. Service users report a high level of satisfaction with the treatment that they receive.

OUTCOME MEASUREMENT

6. The service routinely uses validated measures (e.g. symptoms, level of functioning and/or disability) to inform and evaluate treatment.

THERAPIST TRAINING AND SUPERVISION

7. Therapists are providing therapy under supervision.

8. Therapists have received formal training to deliver the therapy provided.

A full list of references for these standards can be found on the audit webpages.

THE AUDIT

A total of 50 out of 54 NHS Mental Health Trusts in England registered to take part. Trusts registered services that provide psychological therapies in secondary care, including both inpatient and community services. Data to measure performance were collected using three methods – a case note audit, a service user survey and a therapist questionnaire.

Data were also collected about the services themselves, such as what therapies the team provides, how many referrals they receive and how many therapists work in the team.

Jargon buster

Case notes
A document that records a service user's history and which care providers update with the individual's care plan and any drug or psychological treatments prescribed.

What happened in the audit?

People's case notes were eligible for inclusion if:

☑ They were 18 years or over

☑ They ended psychological therapy between 1 September 2017 and 31 August 2018

☒ People's case notes were not eligible if they received a diagnosis of psychosis as this is covered in the National Clinical Audit of Psychosis

* Some Trusts registered more than one service. See **'Limitations of the Audit'** for more information.
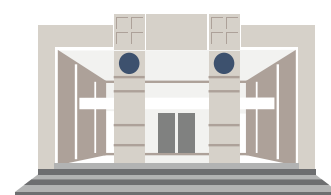
OCT 2018 · NOV 2018 · DEC 2018 · JAN 2019

NHS Trusts sent the RCPsych an **anonymised** list of all eligible service users from each of their services.

The RCPsych **randomly** chose 30 service users from each service to be included in the audit. If the total number of eligible service users was less than 30, then all were included in the case note audit.

Adults who were eligible for the case note audit were also sent the service user survey. All therapists at registered services were sent the therapist questionnaire. Both sets of surveys were returned directly to RCPsych for analysis.

Analysis involved looking for evidence that the standards have been met.

50 NHS Trusts participated and registered a total of **232** services*. Overall, **4,462** service users' case notes, **662** service user surveys and **1,453** therapist questionnaires were analysed.

The next part of this report presents the results from the audit. The results for each standard are presented along with recommendations for improving the quality of care.

A recommendation is given for each standard, followed by why it matters from the perspectives of service users and carers.

Percentages have been rounded to the nearest whole number for ease of reading so some graphs/tables will add to 99% or 101%.

STANDARD 1
The service routinely collects data to assess equity of access

This includes age, gender, ethnicity, employment and accommodation status

Audit results

Age was recorded for
100% of adults

Disability was recorded for
63% of adults.
It was not recorded for
37% of adults

Gender was recorded for more than
99% of adults

Sexual orientation was recorded for
56% of adults.
It was not recorded for
44% of adults

Ethnicity was recorded for
95% of adults.
It was not recorded for
5% of adults

Service users **declined to answer** questions relating to demographics in
1% of cases or less

Accommodation was recorded for
86% of adults.
It was not recorded for
14% of adults

What this means

Important information is not being properly recorded for many service users.

Employment was recorded for
81% of adults.
It was not recorded for
19% of adults

Why it matters

Services collect personal information to see which groups of adults are accessing the service and which are not, enabling them to take steps to reach those not being served. This is what equity of access means.

Asking about personal information is also key to getting a complete picture of the person. This is essential if the clinician is to work out the best way to support the person and write a care plan that takes their current situation into account.

Feedback from service users highlighted how their employment situation and disabilities could have an impact on their access to treatment.

"People with long-term health problems are more likely to have anxiety and depression so it is important to ask about physical health and disabilities."

"Services need to take into account the needs of service users [relating to disabilities] that may make treatment difficult. Are people going to be able to make all appointments? I know some services discharge people if they don't turn up to a certain number of sessions."

"My physical health problems were totally ignored when I went for therapy. My care plan didn't record any physical disabilities, which lead to a break down in trust and relationships."

"I am disabled so it was tricky at times and relied on ambulance transport, my therapist was very accommodating. Sometimes the lift in the place broke but there was always someone to help me."

"Where I had to go generally was very unsuitable for parking and access to the building as I am a stroke survivor and semi-paralysed."

"The sessions were challenging to get to for a person working full-time. My therapist was extremely accommodating, but ultimately my sessions had to cease because I could not fit them into my normal working day."

Recommendation 1

Trusts should:

a) Provide systems that enable clinicians to accurately collect and record comprehensive demographic data, including data on protected characteristics, to ensure services are provided equitably. Collecting and recording information about disability, employment and accommodation status are key areas that require improvement.

Clinicians should:

b) Use demographic data to plan care collaboratively with service users. This should include consideration of potential barriers to accessing and engaging in therapy with particular attention given to the impact of disabilities and employment situation on ability to attend appointments.

STANDARD 2

A person who is assessed as requiring psychological therapy does not wait longer than 18 weeks from the time at which the initial referral is received to the time that treatment starts

Audit results

59% of adults started treatment within **18 weeks of referral**

The **average wait** was **22 weeks**

Crisis resolution/ home treatment teams were most likely to meet the **18-week target**

Specialist services were least likely to meet **18-week target**

59% of adults agreed that their waiting time for treatment was reasonable. **30% disagreed**

Waiting time from referral to first treatment*

%

59%	12%	18%	9%	2%
0-18 weeks	19-26 weeks	27-52 weeks	53-104 weeks	105+ weeks
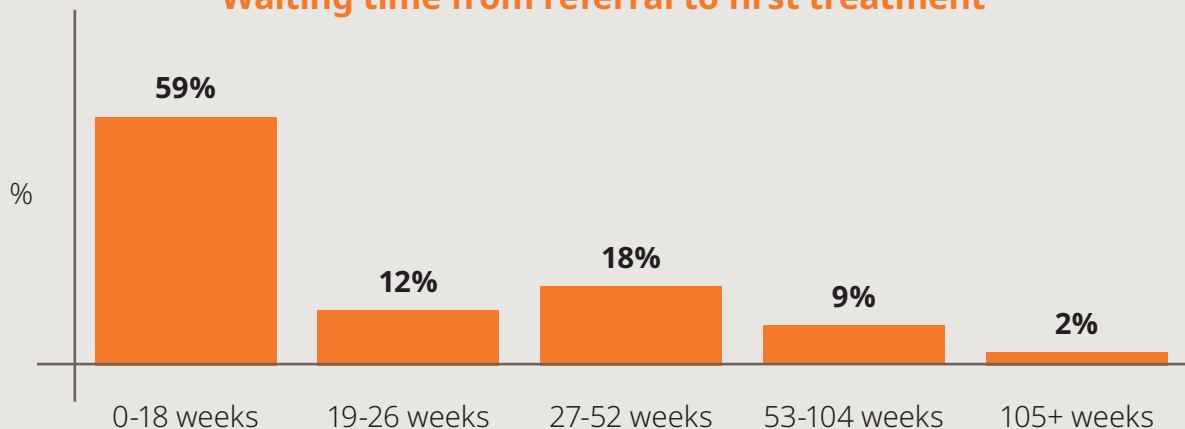
* Waiting time could not be calculated for 542 service users with unknown/not documented referral and/or treatment dates.

What this means

Under half of the adults (41%) included in the audit had to wait longer than 18 weeks.

On average, people over the age of 18 had to wait four weeks longer than the recommended 18 weeks to receive treatment and some had to wait over a year.

Why it matters

Timely access to services means that adults who are in distress can get help when they need it. If they can't access timely support, their condition could deteriorate further.

Furthermore, having to wait for an extended period may mean that by the time the therapy is available, it may no longer be relevant because the person's situation has changed.

"I waited 2 years to get my first appointment. My GP had to constantly contact the services to enquire why I had not yet been seen."

"I waited over twelve months to even get an appointment with a therapist, and when I did get one they decided I was 'too well' for therapy."

"In between referral and start of therapy (about 1.5 years) my mental health deteriorated massively"

"My main concern is that there are no 'penalties' if the target of 18 weeks is not being met. Also, when such targets aren't met, there is very little or no actual accountability by senior managers for this poor delivery."

"If you are acutely unwell to need secondary services, 18 weeks or more is a long time. That is saying nothing of the people who had to wait almost two years."

Recommendation 2

Trusts should:

a) Ensure that systems are in place to monitor waiting times for psychological therapies and that service users who are referred start treatment as promptly as possible.

b) Work actively to increase their capacity to offer psychological therapies in secondary care.

Clinicians should:

c) Provide details of expected waiting times for therapy to start, and details of how to access support while waiting for therapy to commence.

NHS England / NHS Improvement should:

d) Consider what an appropriate waiting time should be for access to psychological therapies for people with severe mental problems.

STANDARD 3

Psychological therapies are provided in line with relevant NICE guidance (type and number of sessions) for the service user's diagnosis/condition

Audit results

65% of service users who were **receiving a psychological therapy** were receiving one in line with relevant NICE guidance for their main presenting problem

CBT was the **most commonly provided therapy***

Adults received **13 sessions** on average

For people receiving a NICE recommended therapy in line with their main presenting problem, **63% ended therapy because they completed treatment.**

Outcome of NICE-recommended therapy

Reason for therapy ending	Number of adults (%)
Completed treatment	63%
Service user discontinued (dropped out)	20%
Referral to another service/therapy	6%
Declined treatment	5%
Not suitable for the service	3%
Other	1%
Therapist unable to continue	1%
Unknown/not documented	1%
Discharged from service	<1%
Deceased	<1%

* Other types of therapy provided will be listed in the online appendices.

What this means

We currently don't know what proportion of people over 18 who could benefit from psychological therapy for anxiety and depression are offered it. Of those service users that are offered therapy, almost two-thirds (65%) were receiving a type of therapy that was in line with NICE guidance for their presenting problem. Just over half of those receiving a NICE-recommended therapy completed the planned number of sessions.

It is not possible from the dataset to state why 35% of service users were receiving a type of therapy that was not explicitly recommended by NICE guidance for their main presenting problem. It may be that people have previously tried the recommended therapy and not responded, or that the type of therapy recommended was not provided by their local Trust. It is known that there is a significant shortage of clinicians in secondary care who have developed all of the specific competencies to deliver NICE recommended therapies.

Why it matters

NICE guidelines are based on clinical evidence. They exist to help health professionals make decisions about the care and services they offer to people and to reassure service users that they are receiving care that is based on the best available clinical evidence.

NICE say that they expect clinicians to consider the guidelines, but that the preferences and circumstances of the individual should also be part of the decision-making process.

"The type of therapy offered should be a result of shared decision-making, the range of options available, and previous experience of the individual about what works and what doesn't."

"Adhering to NICE guidelines is very important because presumably the organisation has information on the best therapy for the illness."

"Previous negative experience of CBT taken into account. Therapist took care to select appropriate therapy."

"I like the therapy but the sessions were not enough. I feel I need more sessions."

"I was given 16 sessions but it became clear I needed more so I was granted an extra 9, a total of 25."

"It would be amazing if it could become practice to provide a follow-up appointment 3-6 months afterwards, where appropriate."

Recommendation 3

Trusts should:

a) Review the availability of psychological therapies with reference to relevant NICE guidance and develop plans to address any gaps in provision.

Clinicians should:

b) Ensure that the type of therapy and number of sessions adheres to NICE guidance and is tailored to an individual's needs and preferences.

STANDARD 4

Service users report being provided with information and choice about their treatment

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Audit results

Information*

62% of adults agreed they received enough information about their therapy before it began. **22% disagreed**

52% agreed they understood where their information is kept, who can see it and when it might be shared. **28% disagreed**

* Survey respondents were asked to choose between strongly agree, slightly agree, neutral, slightly disagree, and strongly disagree.
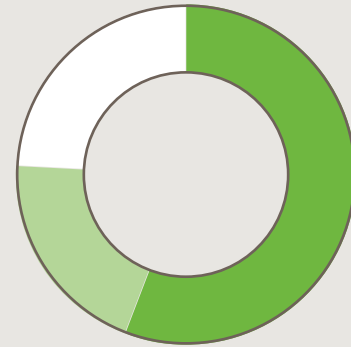
Choice

Service users report being provided with information and choice about their treatment
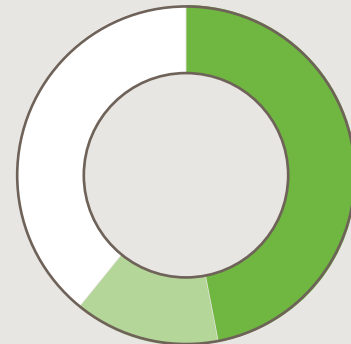
I was offered a choice about...

The type of therapy I would receive

■	"I was given enough choice"	**56%**
■	"I was **NOT** given enough choice"	**20%**
□	"I was **NOT** given **ANY** choice"	**24%**

The venue where my therapy would take place

■	"I was given enough choice"	**47%**
■	"I was **NOT** given enough choice"	**14%**
□	"I was **NOT** given **ANY** choice"	**39%**

The gender of my therapist

■	"I was given enough choice"	**36%**
■	"I was **NOT** given enough choice"	**15%**
□	"I was **NOT** given **ANY** choice"	**49%**
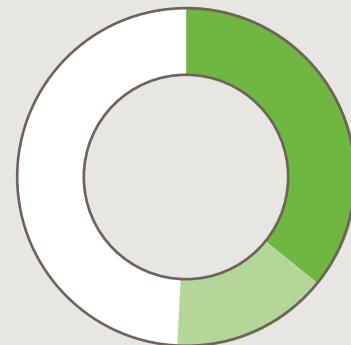
Having therapy in another language/with an interpreter

■	"I was given enough choice"	**42%**
■	"I was **NOT** given enough choice"	**13%**
□	"I was **NOT** given **ANY** choice"	**45%**

What this means

Significant proportions of service users felt they were not given enough information or choice about certain aspects of their care. Having a choice about the type of therapy was most frequently reported as being important and just over half thought they had been given enough choice. Over a quarter of service users (28%) reported that they did not understand how their data was being used.

Why it matters

It is important that service users are given sufficient information and choice so they can be active participants in their treatment plans. It is also important that service users are told how their data will be stored and that full details of confidentiality are outlined from the first contact.

"I wanted individual rather than group therapy. I was told it was very unlikely as there were not enough resources. Essentially, I didn't have any choice. The choice becomes whether you accept or not what you have been given."

"As the therapist is so fundamentally important, the choice of who delivers the treatment should be a serious option and a choice open to me."

"For me, there was no discussion about choosing when I could schedule my appointments. You had to make that time. As someone with disabilities, I had competing hospital appointments but I was told, 'if you don't come at this time, you'll be discharged'."

"For the therapy I received, the only location I knew that offered it was in a town roughly eleven miles away. I didn't have a choice because there were no other choices."

"While choice is very good, I'm not the qualified professional who's making an informed clinical judgement – often I hope the staff member is acting in my best interest but that comes down to trust."

Information and choice must go together – choice is not meaningful unless its impact is explained thoroughly. It is important not to group all service users together in terms of what level of information they need or what amount of choice is desirable for them.

Recommendation 4

Professional leads and service managers should:

a) Ensure that the service supports choice and shared decision-making (including choice of type of therapy, venue, therapist gender, language and time of day).

Clinicians should:

b) Provide service users with information about the treatment options available within the service and support shared decision making.

c) Ensure all service users are clear about where their information is kept, who is allowed to see it, and when it might be shared.

"For us to make an informed choice, yes, we need the right information. To make a real informed choice is often bewildering! In my view, it's best to try [what's on offer] and then I'm able to make an informed choice as to whether it's 'suitable' for me."

STANDARD 5

Service users report a high level of satisfaction with the treatment that they receive

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Audit results

Accessibility of therapy*

85% of adults agreed that their appointments were scheduled on a convenient day/time. **9% disagreed**
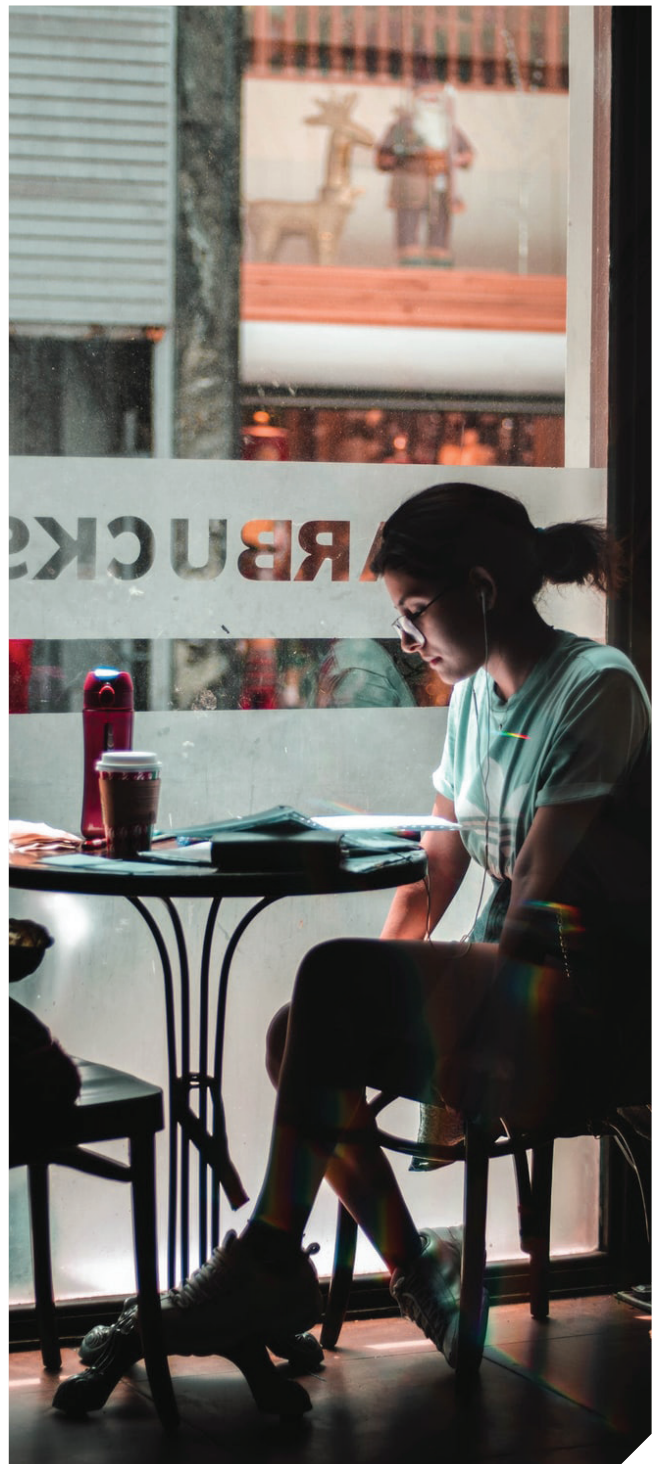
81% of adults agreed that they were able to get to the appointment location without too much difficulty. **12% disagreed**

67% of adults agreed they were referred to therapy at the right time. **23% disagreed**

*Survey respondents were asked to choose between strongly agree, slightly agree, neutral, slightly disagree and strongly disagree.

Experience of Therapy

88% of adults agreed that they were treated with empathy, kindness, dignity and respect. **7% disagreed**

80% of adults agreed that their needs were taken seriously, understood and appropriately considered. **14% disagreed**

76% of adults agreed that together with their therapist they agreed goals for therapy. **12% disagreed**

74% of adults agreed they discussed with their therapist their previous therapy and experiences. **11% disagreed**

68% of adults agreed that they had a discussion with their therapist about their overall care. **16% disagreed**

Outcomes of Therapy

80% of adults agreed their therapy helped them understand their difficulties. **13% disagreed**

75% of adults agreed that their therapy helped them to cope with their difficulties. **18% disagreed**

73% of adults agreed that they got the right kind of help from the service. **18% disagreed**

60% of adults agreed that they received the right number of therapy sessions from this service. **28% disagreed**

14% of adults agreed that they experienced lasting bad effects from treatment. **73% disagreed**

What this means

The areas with the highest service user satisfaction levels were accessibility of therapy in terms of day, time and venue, being treated with empathy and respect, feeling that their needs were taken seriously and understood and finding therapy helpful for understanding their difficulties.

However, almost a quarter of service users who responded to the survey did not think that they had been referred at the right time and a significant proportion did not think that they got the right kind of help or that their therapy helped them to cope with their difficulties. There was also dissatisfaction with the number of therapy sessions and 14% of service users said they had experienced "lasting bad effects from my treatment".

Why it matters

Services exist to help service users and it is important to be able to learn from positive feedback, as well as taking active steps to address dissatisfaction. Service users' subjective experience is as important as any clinical outcome measured by the therapist or any score on a validated measure. If service users are not satisfied with the treatment they receive, this is a problem and may impact the outcome of their treatment.

"My therapist was so kind and reassuring and I never felt like I was being judged or made to feel bad about my problems."

"My therapy was very helpful and has given me strategies to help deal with daily life and understand past trauma."

"My therapist set simple and realistic goals to help increase my self-confidence and lessen my anxiety. This was very helpful."

"I didn't like it that after one 'assessment' session – talking to one woman I'd never met for about 45 minutes – I was labelled with the suggestion of a new diagnosis that I did not feel applied to me at all. That caused me to shut down and I considered dropping out of the service. It also affected my ability to engage with therapy for a long while."

"Group therapy was very difficult for me and the experience was often upsetting."

"This was very helpful but came too late; the therapist agreed, I felt I would have recovered much earlier if I had received CBT at the beginning of my illness."

Service users and carers felt strongly about the number of sessions people were allocated and commented that there is a risk of experiencing lasting bad effects if an issue is not fully addressed before therapy is finished.

The number of sessions provided is complex as it is often affected by the resources available in the service, as well as NICE guidance.

"Finding and exploring triggers helped but something happened at the end of the therapy which set me right back and I didn't have enough time to deal with that with the therapist".
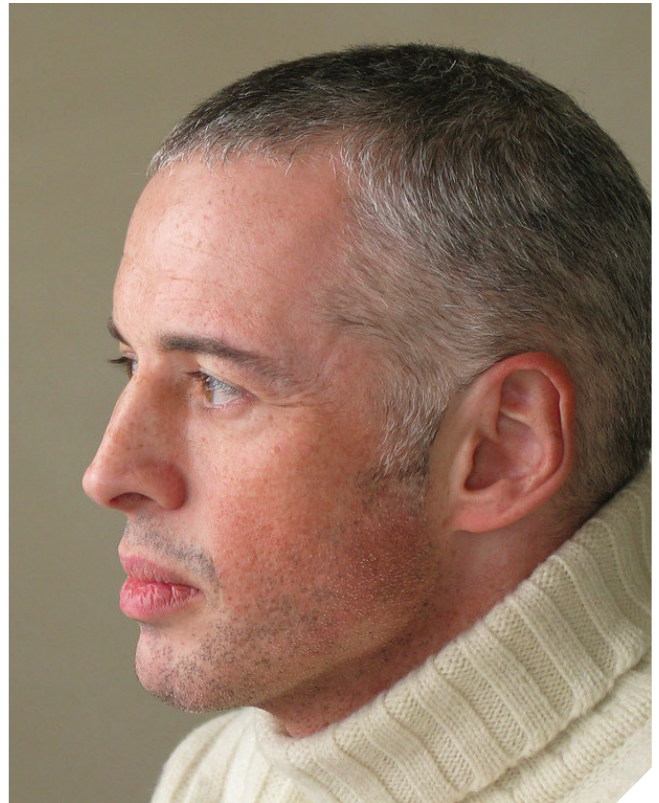
"Therapy always seems too short, especially if therapy is good. If you have a therapist who you like and get on with, you want as many sessions as you can until you stop feeling like this. But the tension is that it obviously can't be infinite."

"I build trust and open up but if I only have two sessions left, then I will just shut down again. I don't want to say something big in last session. Everyone I know gets broadly same amount, 12 sessions. Where is the individual care?"

Recommendation 5

Professional leads and service managers should:

a) Routinely monitor service user satisfaction with psychological therapy and take steps to address sources of dissatisfaction.

b) Ensure that service users are provided with information about who to speak to if they are experiencing difficulties with the therapy process, should they feel unable to address this with their therapist.

c) Involve service users in service development.

STANDARD 6

The service routinely uses validated measures (e.g. symptoms, level of functioning and/or disability) to inform and evaluate treatment

Audit results

In **50% of cases**, there was evidence of an outcome measure being **used at least once**

In **34% of cases**, there was evidence of an outcome measure being **used more than once**

74% of adults reported they discussed their progress with their therapist during treatment. **26% of adults did not**

Most common outcome measures

Outcome measure	Completed initial measure (%)
Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM)	15%
Health of the Nation Outcome Scale (HoNOS)	11%
Patient Health Questionnaire-9 (PHQ-9)	10%
Generalised Anxiety Disorder Assessment (GAD-7)	9%
Clinical outcome in routine evaluation (CORE-10)	9%
Work and Social Adjustment Scale (WSAS)	4%
Hospital Anxiety and Depression Scale (HADS)	3%
Beck Depression Inventory (BDI)	2%
Impact of Events Scale – Revised (IES-R)	1%
Health of the Nation Outcome Scale 65+ (HoNOS 65+)	1%

What this means

Half of service users had been assessed with an outcome measure at least once during their treatment and just over a third had completed them on two or more occasions. This relatively low figure may reflect variation in practitioners' attitudes toward outcomes measures or different preferences for measuring progress.

The majority of service users reported that they had discussed their progress with their therapist, but there was still a significant proportion who said that they had not. This could be affected by some people not completing treatment.

Why it matters

Validated measures are a way for therapists to monitor service users' progress and evaluate whether treatment is working. They can be used as a tool to inform the therapy conversations, aiding shared understanding of progress and sticking points in therapy.

They can be used to inform assessments, but can only be considered an outcome measure if completed more than once, so that any changes over time can be considered.

Outcome measures are also used by services to collect information on the quality of their treatment. These figures are used by Trusts to evaluate their overall performance and to secure funding of psychological therapy services.

"Completing questionnaires during sessions every week to see my progress made me more ill, these questionnaires are horrible, they themselves made me more depressed, because I had to think too much about my depression and issues which made me even worse."

"I found it useful when the therapist completed an outcome measure at the start of each session, because we could explore why my anxiety level was fluctuating weekly. We used this as a tool for conversation and we could identify some of my triggers. But it is important for therapists to explain what this measure means and why they are important."

"Being forced to fill out a repetitive questionnaire isn't enjoyable. It could be made better by discussing its usefulness at the start of therapy, completing it only when the person is ready and allowing them time to process what is being asked of them."

Recommendation 6

Trusts should:

a) Agree and implement reliable systems for assessing the effectiveness of psychological therapies provided to people with anxiety and depression. Consideration should be given to aligning these with the **ICHOM Standard Set for Depression & Anxiety**.

Clinicians should:

b) Work with service users to complete validated outcome measures at a minimum of two time points, explaining the rationale for the measures and how they are used.

c) Ensure that outcome monitoring goes beyond changes in symptoms, and to include reviewing progress against service user defined goals.

STANDARD 7

Therapists are providing therapy under supervision

Audit results

88% of therapists agreed that the clinical supervision they receive is **sufficient** to meet professional body requirements

59% of therapists supervise other therapists in their role in the service. Of these, **91% of therapists had received training** to supervise other therapists

Type of formal clinical supervision therapists received
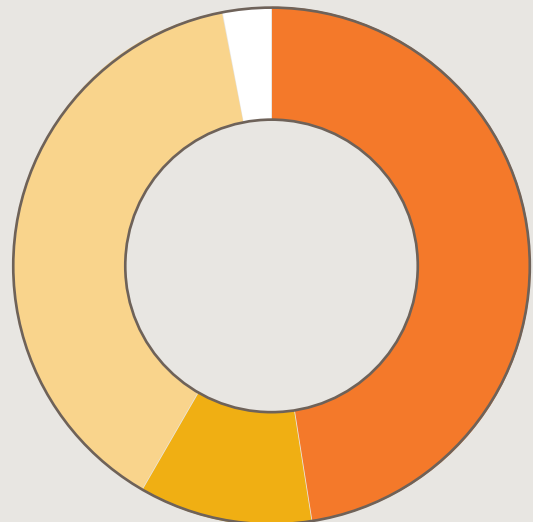
■ Individual supervision	**48%**
■ Group supervision	**11%**
■ Individual and group supervision	**39%**
□ No supervision	**3%**

What this means

All therapists are required to have formal supervision, the amount varying according to the therapist's level of experience, type of therapy provided, and the relevant professional body guidance. Despite supervision being mandatory, 3% of therapists said they are not receiving it in any formal capacity.

Caution should be applied to these results, as the RCPsych found that there was variation in the way that Trusts distributed the survey to staff. It may be that practitioners who indicated that they have no formal supervision meant that they didn't have it in specific therapeutic approaches rather than indicating that they have no supervision at all, or it could mean that there are gaps in formal supervision arrangements in some services.

The findings also indicated that some supervision arrangements needed to be improved to meet professional body requirements.

Why it matters

Supervision is a bedrock of psychological services. It is a breach of professional codes of practice for therapists to not be receiving regular supervision.

Supervision is a means of safeguarding both therapists and service users. It is a chance for therapists to seek guidance and support for their work and an opportunity to raise any challenges.

This is as important for experienced therapists as it is for more junior ones. The demands of psychological services are rigorous and therapists are likely to regularly face difficult interactions and distressing content. Without supervision, it is impossible to ensure safety and quality are maintained.

"If my therapist hadn't had a supervision for 3 months, where is she taking all the stuff she is collecting? This has to impact her ability to work with me and all the other people she is seeing."

"Supervisions should be mandatory. The question it raises is whether the therapist is competent to continue giving therapy?"

"Without a therapist having supervision, I'd be worried whether I was getting competent, legal therapy."

Recommendation 7

Trusts should:

a) Review supervision arrangements and ensure that all therapists are receiving regular and appropriate clinical supervision from a supervisor qualified in the particular therapy being offered.

Clinicians should:

b) Ensure that supervision arrangements are appropriate for the therapies provided on behalf of the service and raise any supervision needs with supervisors and line managers with immediate effect.

STANDARD 8

Therapists have received formal training to deliver the therapy provided

Audit results

44% of therapists

were providing at least one therapy type with **no formal training**

Of these, the majority were **clinical psychologists (48%)**, followed by counselling psychologists **(8%)**, CBT therapists **(7%)** and mental health nurses **(6%)**

67% of therapists

agreed that the continuing professional development support they receive from their service is sufficient to meet the requirements of their professional body. **33% did not agree**

What this means

It is not clear from the data how to interpret these findings as there are many relevant contextual factors. For example, clinical psychologists are trained in many therapies but might not consider themselves 'formally' trained in a particular therapy if they haven't completed further post-qualification training, even though they might have the relevant skills.

There is a growing demand and lack of a shared framework for understanding appropriate training levels for some therapies. This may mean that more staff are learning different therapeutic approaches from short courses, or by reading manuals and seeking supervision rather than by going on extended, formal training courses.

Only two thirds of therapists thought that they were getting enough support from the service to meet the continuing professional development requirements of their professional body.

Some practitioners draw on several therapeutic frameworks within one course of therapy. This is known as working 'integratively'. Therapists who work this way may be more likely to describe themselves as having 'no formal training' in some of the frameworks they draw on.

There is also the possibility that some therapists may have misinterpreted the question and stated that they are not trained when they are also not providing this type of therapy.

Why it matters

Training is essential to ensure service users are receiving the best care possible. While there are numerous models of therapy which can also be blended into an integrative approach, it is important to ensure that therapists' practice is grounded in the evidence base, and that they do not potentially endanger service users by delivering therapies in which they are not trained.

"I'm horrified that someone can be delivering treatment to me who is not qualified to do so."

"I am surprised that so many therapists have no formal training. I have concerns that therapists may be giving the incorrect therapy to the service users which might be a retrograde step for the service user, making situations worse."

"On my last attempt at therapy within a Community Mental Health Team, a psychologist who had not introduced himself other than with his name said that he wanted to do `schema therapy', with no explanation of what this was. He said he wanted me to go back into my childhood memories of very painful events and change these, so they had a happy ending. He said I should take him back into my memories with me. It felt unsafe like it was brainwashing and not suitable for people who have experienced childhood sexual abuse and have difficulties working with males."

"If you go to see a medical doctor you expect them to have medical qualifications to practise. In mental health, you find many different people carrying out therapy who may have different levels of experience. From these results, it doesn't seem regulated at all."

Recommendation 8

Trusts should:

a)   Ensure clinicians have the recognised training to provide the therapies they deliver. This includes evaluation of the qualifications and accreditation status of therapists for each of the therapies that they might provide as part of their clinical role and develop plans for addressing identified training needs.

Professional leads and service managers should:

b)   Identify and address barriers to accessing continuing professional development that will enable therapists to meet the requirements of their professional body and maintain competence in the specific therapies that they deliver.

FULL LIST OF RECOMMENDATIONS

ACCESS AND WAITING TIMES

Standard 1: The service routinely collects data to assess equity of access. Guidance: this includes age, gender, ethnicity, employment and accommodation status.

1

Trusts should:

a) Provide systems that enable clinicians to accurately collect and record comprehensive demographic data, including data on protected characteristics, to ensure services are provided equitably. Collecting and recording information about disability, employment and accommodation status are key areas that require improvement.

Clinicians should:

b) Use demographic data to plan care collaboratively with service users. This should include consideration of potential barriers to accessing and engaging in therapy with particular attention given to the impact of disabilities and employment situation on ability to attend appointments.

ACCESS AND WAITING TIMES

Standard 2: A person who is assessed as requiring psychological therapy does not wait longer than 18 weeks from the time at which the initial referral is received to the time that treatment starts.

2

Trusts should:

a) Ensure that systems are in place to monitor waiting times for psychological therapies and that service users who are referred start treatment as promptly as possible.

b) Work actively to increase their capacity to offer psychological therapies in secondary care.

Clinicians should:

c) Provide details of expected waiting times for therapy to start, and details of how to access support while waiting for therapy to commence.

NHS England / NHS Improvement should:

d) Consider what an appropriate waiting time should be for access to psychological therapies for people with severe mental problems.

APPROPRIATENESS OF THERAPY

Standard 3: Psychological therapies are provided in line with relevant NICE guidance (type and number of sessions) for the service user's diagnosis/condition.

3

Trusts should:

a) Review the availability of psychological therapies with reference to relevant NICE guidance and develop plans to address any gaps in provision.

Clinicians should:

b) Ensure that the type of therapy and number of sessions adheres to NICE guidance and is tailored to an individual's needs and preferences.

SERVICE USER INVOLVEMENT

Standard 4: Service users report being provided with information and choice about their treatment.

4

Professional leads and service managers should:

a) Ensure that the service supports choice and shared decision-making (including choice of type of therapy, venue, therapist gender, language and time of day).

Clinicians should:

b) Provide service users with information about the treatment options available within the service and support shared decision making.

c) Ensure all service users are clear about where their information is kept, who is allowed to see it, and when it might be shared.

SERVICE USER INVOLVEMENT

Standard 5: Service users report a high level of satisfaction with the treatment that they receive.

5

Professional leads and service managers should:

a) Routinely monitor service user satisfaction with psychological therapy and take steps to address sources of dissatisfaction.

b) Ensure that service users are provided with information about who to speak to if they are experiencing difficulties with the therapy process, should they feel unable to address this with their therapist.

c) Involve service users in service development.

OUTCOME MEASUREMENT

Standard 6: The service routinely uses validated measures (e.g. symptoms, level of functioning and/or disability) to inform and evaluate treatment.

6

Trusts should:

a) Agree and implement reliable systems for assessing the effectiveness of psychological therapies provided to people with anxiety and depression. Consideration should be given to aligning these with the **ICHOM Standard Set for Depression & Anxiety**.

Clinicians should:

b) Work with service users to complete validated outcome measures at a minimum of two time points, explaining the rationale for the measures and how they are used.

c) Ensure that outcome monitoring goes beyond changes in symptoms, and to include reviewing progress against service user defined goals.

THERAPIST TRAINING AND SUPERVISION

Standard 7: Therapists are providing therapy under supervision.

7

Trusts should:

a) Review supervision arrangements and ensure that all therapists are receiving regular and appropriate clinical supervision from a supervisor qualified in the particular therapy being offered.

Clinicians should:

b) Ensure that supervision arrangements are appropriate for the therapies provided on behalf of the service and raise any supervision needs with supervisors and line managers with immediate effect.

THERAPIST TRAINING AND SUPERVISION

Standard 8: Therapists have received formal training to deliver the therapy provided.

8

Trusts should:

a) Ensure clinicians have the recognised training to provide the therapies they deliver. This includes evaluation of the qualifications and accreditation status of therapists for each of the therapies that they might provide as part of their clinical role and develop plans for addressing identified training needs.

Professional leads and service managers should:

b) Identify and address barriers to accessing continuing professional development that will enable therapists to meet the requirements of their professional body and maintain competence in the specific therapies that they deliver.

WHAT HAPPENS NEXT?

For Trusts and services

Trusts are asked to examine the results included in this report and the additional analysis on the NCAAD webpages for further details on how they are performing against national data. In addition to this publicly available information, individual Trusts will also be sent a report with local data that will enable them to see how their service is performing against the national average.

Topic areas that are identified as needing improvement will be the focus of quality improvement webinars, delivered by the RCPsych in 2020, that all Trusts are invited to attend.

For service users and carers

There are several ways for people to voice their concerns about their local mental health services. They may also wish to get involved in how services are run in order to help improve them.

Concerns and complaints

- People who want to report concerns about performance should initially approach their local **Patient Advice and Liaison Service (PALS)**. You can find your local PALS by visiting https://www.nhs.uk/Service-Search/Patient-advice-and-liaison-services-(PALS)/LocationSearch/363

- **Healthwatch** is an independent "national champion" for people who use health and social care services in England. They focus on "ensuring that people's worries and concerns about current services are addressed". You can find your local Healthwatch by visiting https://www.healthwatch.co.uk/your-local-healthwatch/list

Shaping services locally and nationally

Local involvement

Opportunities to get involved locally vary between areas.

- To shape how services are run from the ground up, consider getting involved with your local **Clinical Commissioning Group (CCG)**. These are the bodies that plan and buy healthcare services for people in their area. More information about how to get involved is available at https://www.england.nhs.uk/participation/get-involved/local/

- Some other suggestions to discover what is available in your area include contacting your hospital Trust to find out if they have an active service user and carer involvement group or a disability forum, speaking to someone involved in your care, and contacting any local mental health charities or patient organisations.

- You may also find that PALS or your local Healthwatch may be able to provide further information.

National involvement

- To get involved specifically with mental health services, consider becoming a "participating stakeholder" for a mental health **Clinical Reference Group (CRG)**. CRGs are groups of clinicians, commissioners, public health experts, service users and carers who use their knowledge and expertise (including that gained through lived experience) to advise NHS England on the best ways that specialised services, such as mental health services, should be provided.

- You can read more about CRGs and how to register as a stakeholder at https://www.england.nhs.uk/commissioning/spec-services/npc-crg/

- For more information about getting involved in NHS England mental health services generally, visit https://www.england.nhs.uk/commissioning/spec-services/get-involved/

For the RCPsych

RCPsych will be conducting a focused analysis of the qualitative feedback collected in the service user survey from this audit of psychological therapy services. This will form the basis of another NCAAD audit. The aim is to expand on some of the issues that have been identified by service users in this report and the previous NCAAD audit report, regarding their experiences of secondary care mental health services. This report will be published in the summer of 2020.

The NCAAD team have developed a data collection system that will enable Trusts to track in real time how their services are performing against the standards, by comparing data from their services to national and regional data. It is hoped that this system will reveal what improvements have been made following the publication of the recommendations, when Trusts are re-audited in 2020.

For the BPS

The BPS Division of Clinical Psychology (DCP) will work with the RCPsych to support the quality improvement work, prioritising the development and support of Trust-wide coordination of improvements to psychological therapy provision. It will help ensure that the audit findings are disseminated widely to professional and trainee practitioners.

LIMITATIONS OF THE AUDIT

What was not measured in the audit?

The audit did not measure the proportion of service users with anxiety or depression who were offered psychological therapy.

In addition, many who could benefit from therapy may never be "referred" as there is insufficient capacity. This hidden access barrier was not measured in this audit, so we don't know the proportion of those with anxiety and depression who were offered a referral.

The data are not distributed similarly across Trusts

Although it is expected that NHS Trusts participate in audits that are part of the National Clinical Audit Programme commissioned by HQIP, not all services that were eligible to take part participated. The most common reason for this was that there were not enough resources within some services to complete data collection. In order to ease this burden, some Trusts grouped together similar services and registered them as one, which meant they could collect data for 30 service users across all of them, rather than having to do it for each individual service.

Services vary in size. Some specialist services might not have had 30 eligible cases to submit to the audit whereas larger services would have had a bigger case load from which to submit data for. Some Trusts have more psychological therapy services than others. This means there will be a wide variation in the data.

This matters because estimates of the performance of Trusts become less reliable when data were returned on fewer service users. Caution should be used when interpreting the performance of services that returned data on fewer than 20 service users. Full details of completion rates for each Trust and service can be found on the audit webpages.

Case notes might not always reflect what happened

In the case note audit, data were collected from the case notes of service users who have been discharged from psychological therapy services. The data captured information that was recorded in peoples' case notes or can be inferred from them. The information was then used to decide whether a service is meeting the required standard.

There is a possibility that activities might have taken place but weren't recorded in the case notes. For example, if a clinician asked about a service user's housing situation but did not record it in the notes, the audit would count this as not being asked about.

Survey data is not representative of all service users

Unlike the NCAAD core audit, this audit also included a service user survey. This meant individuals who had been discharged from psychological therapy services participating in the audit were able to give their feedback on their experiences of receiving therapy. This enabled the case note data to be explored further, for example, capturing peoples' opinions on waiting times. However, not all services participated in the service user survey component of the audit, and not all eligible service users decided to take part.

There is a risk that adults who have had very good, or very bad, experiences might be more likely to complete a feedback survey. The survey data is therefore not representative of all eligible service users who have accessed psychological therapy services, but it does give us a good indication.

WHO WAS INVOLVED?

- H F Borscha Azmi, *former NCAAD Project Officer, RCPsych*

- Nick Barber, *NCAAD Service User Representative*

- Professor David S. Baldwin, *NCAAD Clinical Lead, RCPsych*

- Paul Bassett, *Statistician, Statsconsultancy Ltd*

- Jessica Bond, *Communications Manager, McPin Foundation*

- Francesca Brightey-Gibbons, *former NCAAD Programme Manager, RCPsych*

- Emily Coll, *Project Officer, RCPsych*

- Professor Mike Crawford, *Director of the Centre for Quality Improvement (CCQI), RCPsych*

- Dr Mary Dang, *NCAAD Programme Manager, RCPsych*

- Dr Lorna Farquharson, *Clinical Advisor to the Psychological Therapies Spotlight Audit, RCPsych*

- Naomi FitzPatrick, *NCAAD Project Officer, RCPsych*

- Cassandre Greenberg, *Communications Intern, McPin Foundation*

- John Hildreth, *former Deputy Programme Manager, RCPsych*

- Emily Lesnik, *former NCAAD Deputy Programme Manager, RCPsych*

- Natasha Lindsay, *NCAAD Project Officer, RCPsych*

- Dr Keith Miller, *Division of Clinical Psychology London Committee, BPS*

- Aimee Morris, *former NCAAD Project Officer, RCPsych*

- C. Newton, *NCAAD Carer Representative*

- Dr Roman Raczka, *Chair of the Division of Clinical Psychology England, BPS*

- Dr Alan Quirk, *CCQI Head of Clinical Audit and Research, RCPsych*

- Ellen Rhodes, *NCAAD Deputy Programme Manager, RCPsych*

- Prisha Shah, *NCAAD Service User Advisor, RCPsych*

- Chris Wright, *NCAAD Service User Advisor*

Thank you to all the service users and carers who contributed to the audit, and to those who gave their time and insight to co-create this report.

Psychological Therapies Audit Steering Group

- Alison Brabban, *Clinical Advisor to Adult Mental Health Programme, NHS England*

- James Campbell, *Associate Director, HQIP*

- Linda Chadburn, *Pennine Care*

- Jeremy Clarke, *Chair and Research & Practice Lead, Association for Psychoanalytic Psychotherapy in the NHS*

- Esther Cohen-Tovee, *Chair of the British Psychological Society's Division of Clinical Psychology, BPS*

- Wendy Harlow, *Sussex Partnership*

- Sam Harper, *Project Manager, HQIP*

- Geoff Heyes, *Head of Policy and Campaigns, Mind*

- Lorraine Knibbs, *President Elect, EMDR UK & Ireland*

- Roslyn Law, *Chair, IPTUK*

- Del Lowenthal, *Chair, Universities Psychotherapy & Counselling Association*

- Sue Mizen, *Faculty Chair, RCPsych Faculty of Medical Psychotherapy*

- Felicitas Rost, *President, Society for Psychotherapy Research*

- Paul Salkovskis, *President, British Association for Behavioural and Cognitive Psychotherapies*

- Dave Smithson, *Operations Director, Anxiety UK*

- Toby Sweet, *Chief Executive, Sunderland Counselling Service, British Association for Counselling and Psychotherapy*

- Chris Williams, *former President, British Association for Behavioural and Cognitive Psychotherapies*

- Rory Worthington, *UK Council for Psychotherapy*

Members of the Steering Group are asked to declare any conflict of interest at the outset and prior to each meeting. This is included as a standing item on the agenda.

Should a conflict of interest affecting the conduct or results of the audit be declared, the member may be asked to absent themselves from all or part of the discussion, at the meeting and subsequently.

APPENDICES

NICE-recommended psychological interventions

Condition	Psychological therapies	Source
Depression For individuals with mild to moderate severity who have not responded to initial low-intensity interventions	CBT (individual or group) or IPT, behavioural activation, couple therapy, counselling for depression, brief psychodynamic therapy Note: psychological interventions can be provided in combination with antidepressant medication	NICE guidelines: CG90 CG91
Depression Moderate to severe	CBT (individual) or IPT, each with medication	NICE guidelines: CG90 CG91
Depression Prevention of relapse	CBT or mindfulness-based cognitive therapy	NICE guidelines: CG90 CG91
Generalised anxiety disorder	CBT, applied relaxation	NICE guidelines: CG113
Panic disorder	CBT	NICE guidelines: CG113
Post-traumatic stress disorder	Trauma focused-CBT, eye movement desensitisation and reprocessing	NICE guidelines CG26
Obsessive-compulsive disorder	CBT (including exposure and response prevention)	NICE guidelines: CG31

The following online appendices can be found on the NCAAD webpages (**www.rcpsych.ac.uk/ncaad**).

- Methodology
- Eligibility criteria
- References for the standards
- Demography of the audit sample
- Participating Trusts
- Types of registered services
- Trusts variance charts
- Audit tools

SOURCES OF SUPPORT

If you need support for your own mental health or that of a loved one, below are some helplines and links which you may find helpful:

Adfam

National charity working with families affected by drugs and alcohol. Publications and resources, online message board and local support groups.

www.adfam.org.uk

Anxiety UK Infoline

Telephone: 0344 477 5774

Offers practical advice and information on support services that are available. Open weekdays 9.30am to 5.30pm. You can also email support@anxietyuk. org.uk or chat online via their website.

www.anxietyuk.org.uk

Carers Direct

Telephone: 0300 123 1053

Confidential information, advice and support for carers. Lines are open 9am to 8pm, Monday to Friday, 11am to 4pm at weekends.

Request a free call back or an interpreted call back in one of more than 170 languages.

**www.nhs.uk/carersdirect/Pages/
CarersDirectHome.aspx**

Carers UK

Telephone: 0808 808 7777

Information, advice and support for carers including information about practical issues, looking after yourself and details of local support groups. Lines are open Monday to Wednesday 10am to 4pm (listening service available Mondays and Tuesdays, from 9am to 7pm).

www.carersuk.org

HOPELine

Telephone: 0800 068 4141

Offers confidential advice and support to young people under the age of 35 having thoughts of suicide.

Open 10am to 10pm weekdays, 2pm to 10pm weekends. You can also text 07786 209697 or email pat@papyrus-uk.org.

www.papyrus-uk.org/hopelineuk

Mind

Telephone: 0300 123 3393

The Infoline offers information and advice on all issues relating to mental health and information about Mind associations and other support services in your area. Lines are open 9am to 6pm. Email info@mind.org.uk

www.mind.org.uk

National Self-Harm Network

Network supporting people and their families on issues around self-harm. Information, campaigning and practical support, including discussion forums. NSHN, PO Box 7264, Nottingham, NG1 6WJ Email info@nshn.co.uk

www.nshn.co.uk

National Survivor User Network

A diverse, inclusive user-led network which aims to improve the lives of people who experience mental distress. NSUN, PO Box 74752, London, E11 9GD Email info@nsun.org.uk

www.nsun.org.uk

NHS Direct

0845 46 47 or **111** depending on where you live.

A 24-hour telephone advice and information service which is part of the National Health Service. (NHS Direct has an obligation to call out emergency services if they are concerned about your safety.)

Samaritans

FREE Helpline: 116 123

Confidential emotional support for anyone, 24 hours a day, 7 days a week. You can also e-mail jo@samaritans.org for support, or write to: 'Chris' P.O. Box 9090, Stirling, FK8 2SA. Some centres also offer face to face support, usually by appointment.

www.samaritans.org

Saneline

Telephone: 0300 304 7000

Offers practical care and support to anybody affected by mental health problems. Open every day of the year between 4:30pm to 10:30pm.

The British Psychological Society

We act as the representative body for psychology and psychologists in the UK. We are responsible for the promotion of excellence and ethical practice in the science, education, and application of the discipline. **www.bps.org.uk**

The McPin Foundation

We are a mental health research charity. We champion experts by experience in research so that people's mental health is improved in communities everywhere. **www.mcpin.org**
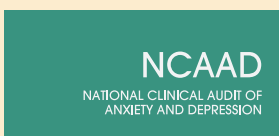
Royal College of Psychiatrists

We work to secure the best outcomes for people with mental illness, learning difficulties and developmental disorders by promoting excellent mental health services, training outstanding psychiatrists, promoting quality and research, setting standards and being the voice of psychiatry. **www.rcpsych.ac.uk**