

King's Health Partners

King's Health Partners brings together:

- three of the UK's leading NHS Foundation Trusts
- a world-leading university for health research and education
- nearly 4.8 million patient contacts each year
- 40,000 staff
- nearly 30,000 students
- a combined annual turnover of more than £3.7 billion
- services provided across central and south London and beyond, including nine mental health and physical healthcare hospitals and many community sites
- a comprehensive portfolio of high-quality clinical services with international recognition in cancer, diabetes, mental health, regenerative medicine, transplantation, cardiac and clinical neurosciences
- a major trauma centre and two hyper-acute stroke units

About King's Health Partners

King's Health Partners Academic Health Sciences Centre brings together one of the world's top research-led universities, King's College London, and three of London's most prestigious and highly-regarded NHS Foundation Trusts – Guy's and St Thomas', King's College Hospital and South London and Maudsley.

Our partnership provides a powerful combination of complex clinical specialties that cover a wide range of physical and mental health conditions and a breadth of research expertise that spans disciplines from medicine and biomedical sciences to the social sciences and humanities.

There are three parts to our mission: excellence in research, education and clinical care.

To support our mission, we are delivering programmes of work to:

- join up mental and physical healthcare so that we treat the whole person, mind and body

- increase the value of the care we provide and the outcomes we achieve for our patients and service users
- integrate care across local primary, secondary and social care services to make it easier for people to get the care and support they need
- improve the public health of our local community by tackling inequalities and supporting people to live healthy lives
- bring together our collective strength and expertise in a range of specialist areas to deliver world-leading care, research and education.

We are uniquely structured to deliver our mission for excellence. Our 21 Clinical Academic Groups (CAGs) bring together all the clinical services and staff from the three trusts with the relevant academic departments of King's College London.

Foreword



Professor John Moxham, Director of Clinical Strategy

At King's Health Partners, we are committed to improving outcomes for our patients and service users and achieving maximum value for money in everything we do. We believe that being open and transparent about the care and outcomes we deliver results in a culture of improvement across our partnership. This is why we are publishing a series of outcomes books that will help patients, service users, carers, referring clinicians and commissioners to make better-informed decisions, and our staff to drive up the quality of the care we provide. The books report key outcomes for treatments provided by our 21 clinical academic groups (CAGs). CAGs form the building blocks of our Academic Health Sciences Centre. By bringing together our clinical and academic staff across teaching, training and research, we can use their combined expertise to achieve better outcomes for our patients and service users.

Our books are designed for a clinical and lay audience and contain a summary of patient volumes and measures (e.g. length of stay, re-admissions, patient experience), clinical outcomes, educational activities, technological and research innovations and publications. They also focus on other important measures, such as staff satisfaction and wellbeing.

The primary purpose of King's Health Partners is to improve health and wellbeing, locally and globally. We must deliver this goal in a challenging economic environment with rising demand for, and costs of, healthcare. We will only achieve sustainable health improvement if we strive always to increase value. We define value in terms of outcomes that matter to patients, over the full cycle of care, divided by the cost of producing those outcomes. By publishing outcomes books, we have more information to support us measuring the value of the healthcare we provide.

Our goal is to increase the depth and breadth of reporting each year. Books will be updated regularly to demonstrate progress against our mission to achieve world-class research, education and clinical care. We hope you find these data valuable. Please send comments and suggestions to us at kingshealthpartners@kcl.ac.uk. For more information please visit our website at www.kingshealthpartners.org.

Professor John Moxham, Director of Clinical Strategy, King's Health Partners

August 2017

A handwritten signature in black ink that reads "John Moxham". The signature is written in a cursive style with a long horizontal line extending to the left.

A word from the CAG Leadership

The Mood, Anxiety and Personality (MAP) CAG brings together many centres of excellence in the South London and the Maudsley NHS Foundation Trust (SLaM) and the Institute of Psychiatry, Psychology and Neurosciences (IoPPN). Together we are developing a real partnership between those working at the forefront of research, education and patient care. By harnessing the 'virtuous' synergistic interaction between these three domains, we aim to translate research findings into clinical delivery without delay, resulting in better mental health for both our local population and those who are referred to us nationally and internationally.

Increasing numbers of the population have both a physical and a mental health long term condition. A key focus for the MAP team over the next five years will be to consider how healthcare delivery might be centred on the whole person, with fully-integrated physical and mental healthcare. The CAG workforce is our greatest asset and they will thrive if valued, supported and educated to consider the whole system, unconstrained by traditional healthcare boundaries. We also need to collaborate with

key partners in the community to promote health and wellbeing.

This book showcases our achievements since 2010 and the activities under way to weave education and training, research and clinical services into integrated delivery units whose performance is judged against metrics spanning the tripartite agenda. We hope that it shows the quality of the care we deliver and serves as a useful benchmark for future reports charting our progress.

In July 2016, the MAP CAG was merged with specialist services previously within the Psychological Medicine CAG. The new CAG is named Psychological Medicine and Integrated Care CAG and we have been building an integrated approach over our first year.

**Prof Allan Young, CAG Lead
and Academic Director**

Dr Hugh Jones, CAG Lead and Clinical Director

Mr Steve Davidson, Service Director

The value of partnership at King's Health Partners

King's Health Partners aims to create a centre where world-class research, education and clinical practice (the 'tripartite mission') are brought together for the benefit of patients.

We want to make sure that the lessons from research are used swiftly, effectively and systematically to achieve better patient outcomes, improve public health and join up health and care services for people with physical and mental health problems.

By working together in this way, integrating care across different organisations and sectors, we can not only improve the health of the people we care for, but we can also achieve better value for money.

Integrating mental and physical health

The mind and body are inseparable, and mental and physical health conditions are often connected.

The average life expectancy for someone with a long-term mental health illness is much shorter than for someone without, often due in part to smoking, obesity, diabetes or alcohol misuse. Likewise, many people with long-term physical health conditions suffer from depression or other mental health conditions.

Despite this, health services separate care into physical and mental and often fail to share patient information.

At King's Health Partners, we are working to overcome these barriers by treating the whole person. We are committed to caring for vulnerable patients with both physical and mental ill health in an integrated manner with better, faster diagnosis and treatment because we know that addressing mental ill health improves physical health outcomes and vice versa.

Right across our partnership, we are committed to joining up and delivering excellent mental and physical healthcare, research and education so that we treat the whole person, by:

- screening all patients with chronic physical diseases for mental health conditions, and using the learning from this to improve the care we provide
- improving our understanding of the physical health needs of people with severe mental ill health
- addressing the traditional distinctions between the mind and body in research and education, allowing us to train students and staff to deliver more integrated care
- better organising and expanding current training provision for physical and psychiatric comorbidity
- working with our local commissioners to find new ways of paying for integrated services

- linking IT systems across our partner trusts so that clinicians have access to a person's physical and mental care records
- investing in innovative programmes such as IMPARTS (Integrated Mental and Physical Healthcare: Research, Training and Services) and 3DfD (3 Dimensions of care for Diabetes)
- recognising the importance of employee mental and physical health and wellbeing.

Public health

Public health is one of our biggest challenges. At the root of much of the ill health in south London is a high incidence of smoking, alcohol abuse and obesity. With our health and social care partners, we are developing strategies to tackle these public health priorities. We are also developing plans for a new Institute for Urban Population Health, a collaboration with local partners to bring about transformational change to health in local communities. We want to achieve a measurable improvement and impact on health gain and local management of physical and mental health problems through new evidence based interventions.

Alcohol strategy – key aims

- developing appropriate resources for clinical staff and patients

- developing and implementing training for allstaff on harmful drinking, supporting early identification and intervention
- establishing ourselves as a centre of excellence for integrated research, training and practice in the management and prevention of alcohol misuse
- attracting funding for future alcohol clinical, training and research initiatives
- monitoring the impact of the strategy on indicators of alcohol-related harm.

Tobacco strategy – key aims

- supporting all clinical sites to be smoke-free
- developing an informatics structure for routinely and systematically recording smoking status
- support, referrals and treatment uptake for smoking cessation across the partnership
- co-producing clinical care pathway for nicotine dependence treatment
- developing and implementing training packages for smoking cessation interventions for all our healthcare professionals
- monitoring the impact of our smoking cessation strategy in relation to knowledge and uptake of skills by staff, uptake of















smoking interventions, outcomes of interventions, user satisfaction, prevalence of smoking, cost-effectiveness of interventions.

Informatics

Informatics is at the heart of our plans to join up care, research and education. Data is one of our most important assets at King's Health Partners. We are proud of our ability to control information systems for the purpose of data creation, curation and analysis, with strong and transparent information governance processes throughout. This control enables our exploration of the relationship between clinical and biological data, extending at one end to clinical decision support embedded in electronic medical records (EMRs), sharing of clinical data to enhance care and outcomes, through to research recruitment and participation, with strong patient engagement throughout. We have developed a clear strategy and action plan to maintain and develop leadership in the field of informatics.

Systems have been developed to enable electronic healthcare records to be shared across our partner organisations and with other healthcare organisations. Our work includes the award-winning 'MyHealthLocker' programme, the Clinical Record Interactive Search (CRIS) and King's Health Partners Online. We are working with patients to make electronic patient information available in an anonymised format between partner trusts, primary care and social care. Together we have a powerful information resource for both practitioners and researchers.

Contents

	Introduction	08
	CAG leadership	11
	Our aims, ambitions, priorities	12
	Our pathways and services	14
	Key achievements demonstrating the tripartite mission	16
	Which outcomes do we use?	21
	Anxiety care pathway	28
	Recurrent affective disorders	47
	Personality disorders	72
	Engagement, Assessment and Stabilisation	86
	Education and training	94
	Staff satisfaction	96
	Research income for the CAG	100
	Publications	102

Introduction

The Mood, Anxiety and Personality (MAP) CAG provides a large range of services for people with mood, anxiety, personality and trauma disorders; including depression and self harm. According to the Psychiatric Morbidity Survey in 2007, the proportion of people aged 16–64 meeting the criteria for at least one common mental disorder (CMD) increased between 1993 and 2000, but did not change between 2000 and 2007 (15.5% in 1993, 17.5% in 2000, 17.6% in 2007). The largest increase in rate of CMD between 1993 and 2007 was observed in women aged 45–64, among whom the rate rose by about a fifth.

Services are provided for people living in Croydon, Lambeth, Lewisham and Southwark and for patients from around the country who need specialist care. We provide assessment in the community, and treatment where patients can access talking therapies and social care for self-help and problem-solving to intensive day services. We also provide inpatient and outpatient services for people who need more intensive treatment and support.



Where our main services are



Channel 4 Bedlam

SLaM offered unprecedented access to our clinical services for a documentary series for Channel 4 which was aired in October 2013 for four episodes. The aim was to challenge the myths, taboos and stigma around mental illness and its treatment in Britain today.

The series specifically looked at the Anxiety and Crisis services at Lambeth Hospital, which are provided by the MAP CAG.



Source: SLaM communications

CAG leadership



Dr Hugh Jones
Clinical Director



Professor Allan Young
Academic Director



Mr Steve Davidson
Service Director

The Mood, Anxiety and Personality Outcomes Book reflects the collective achievements of all who worked in the Mood, Anxiety and Personality Clinical Academic Group (MAP-CAG) over the course of its existence. These are the achievements of the hundreds of people who worked in the MAP-CAG and the Outcomes Book both recognises these achievements and what we have learnt from them. Health systems change and the MAP-CAG has since amalgamated

with the Psychological Medicine CAG to form the Psychological Medicine and Integrated Care CAG. Notwithstanding this change, the needs of patients and the commitment of clinicians, researchers and teachers to Mood, Anxiety and Personality Disorders endures. These outcomes achieved by the MAP-CAG are relevant benchmarks for the future and we record and celebrate them here.

Our aims, ambitions, priorities

Aim and ambitions for 2017 and beyond

We aim to be the main treatment and research centre in the UK for mood, anxiety and personality disorders, adhering to the highest standards in clinical care, management and academic activities.

Building on achievements as a UK leader in research and clinical treatment of anxiety through the Centre for Anxiety Disorders and Trauma (CADAT), the MAP CAG launched the Centre for Affective Disorders (CfAD) in June 2013. It is headed up by Professor Allan Young and coordinates our research in mood, bringing together many experts in this field. Affective disorders are projected to become the leading contributor to the global burden of disease by 2020, reflected in a notable expansion of mental health services for this target group.

The CfAD's research will focus on developing new treatments, particularly for people with bipolar

disorder and treatment-resistant depression. We are already a world leader in education, underlined by the establishment of the first MSc in Affective Disorders programme which started in September 2015. The programme provides world-class specialised graduate training in affective disorders, with a strong clinical element. A multidisciplinary approach is used, capitalising on the most recent findings from a range of disciplines including psychiatry, psychology, genetics, neuroscience, psychopharmacology, epidemiology and biostatistics.

Another key priority is to enhance care for patients with personality disorders through early detection in young people and cross-CAG collaboration for patients who access several services or those with multiple diagnoses (e.g. Bipolar Disorder).

Since 1st July 2016, we are responsible for the following specialist services: eating disorders, mother and baby, psychosexual, neuropsychiatry, memory disorders, chronic fatigue and medically unexplained symptoms, liaison psychiatry and HIV in the context of mental health. We aim to

integrate these into our care model in order to provide a seamless transition between services for patients.

We will show our commitment to integrated healthcare by developing a CAG-wide research strategy which is both informed by and supports the development of the CAG's clinical pathways, as well as staff training and education. This will include developing approaches to increase the involvement of CAG service users and carers in research. The CAG also supports SLaM-wide initiatives such as Consent for Contact,¹ the Trust's patient research participation register. We are committed to KCL's equality objectives, including increasing the proportion of women in senior academic roles and the representation of Black and Minority Ethnic (BME) academic and non-academic staff, and improving the participation of disabled students and staff.

¹ www.slam.nhs.uk/research/patient-involvement/current-opportunities/consent-for-contact

Our pathways and services

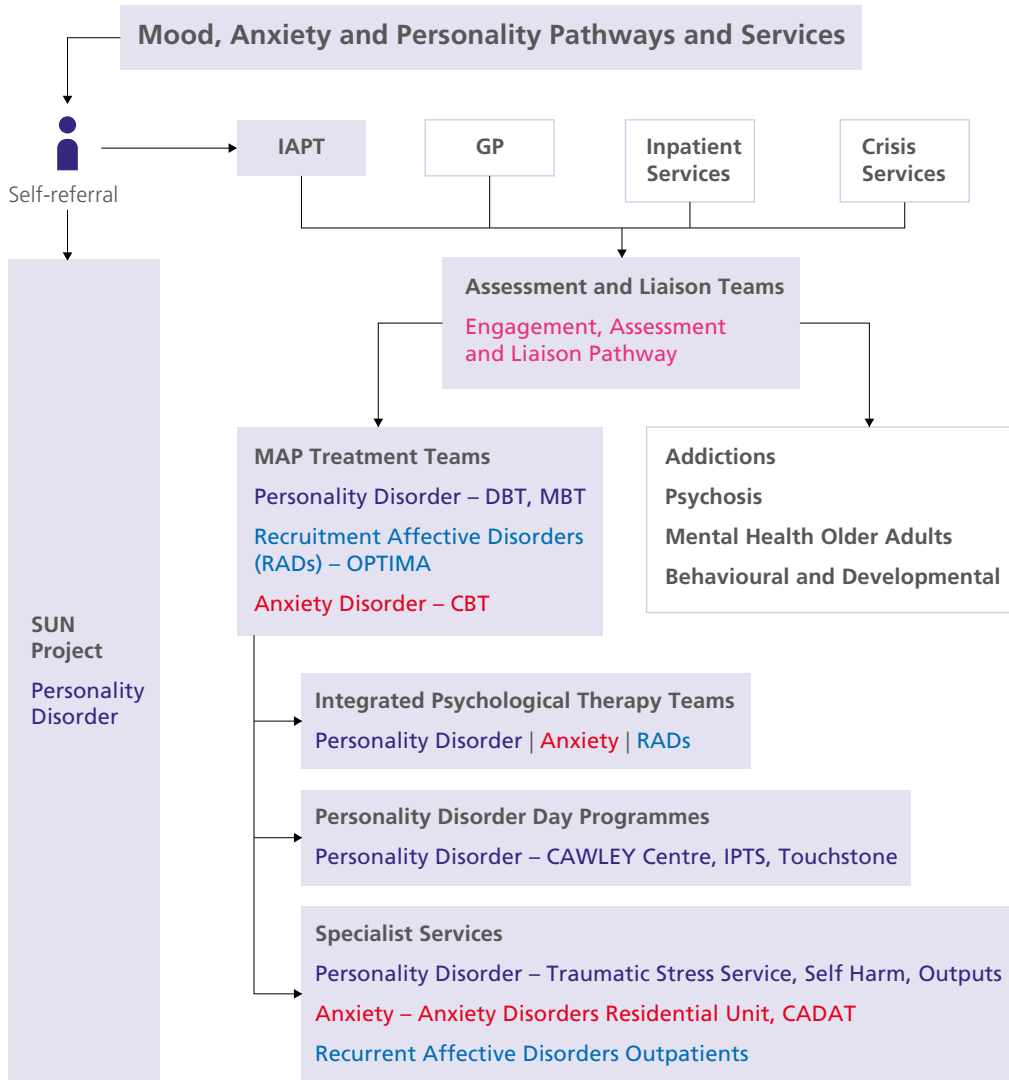
How our services work together

The diagram on the following page is colour-coded according to care pathway and shows how patients are referred to each service. Each box represents a service or service type; unshaded boxes are outside the MAP CAG (e.g. GP, other CAGs). The arrows show the order/direction in which patients are referred to services.

Key:

- **DBT**
Dialectical Behavior Therapy is a type of therapy specifically designed to treat people with Borderline Personality Disorder (BPD)
- **MBT**
Mentalisation-Based Therapy is another type of long-term psychotherapy that can be used to treat BPD
- **OPTIMA**
The OPTIMA Mood Disorders Service is an intensive day programme for people of working age with bipolar disorder who have recently had several hospital admissions for an affective episode
- **CBT**
Cognitive Behavioural Therapy
- **RADs**
Recurrent Affective Disorders
- **IPTS**
Intensive Psychological Treatment Service
- **CADAT**
Centre for Anxiety Disorders and Trauma

Figure 1 | How patients are referred to each of the care pathways



Key achievements demonstrating the tripartite mission

Integration of physical and mental health care

Southwark Improving Access to Psychological Therapies (IAPT) service provides a wide range of treatment options for people with long term conditions or medically unexplained symptoms. This includes specific cognitive-behavioural protocols for individuals with chronic fatigue syndrome, chronic pain, fibromyalgia, irritable bowel syndrome, diabetes and chronic obstructive pulmonary disease. MAP CAG researchers Katharine Rimes and Janet Wingrove, together with Psychological Medicine CAG colleagues, produced a set of competencies required for therapists delivering CBT for people with chronic fatigue syndrome or irritable bowel syndrome, published in 2014 (see Publication section for details).

Southwark IAPT also runs a weekly group for people with long term physical conditions and depression and anxiety. It provides psycho-education, relaxation skills, mindfulness techniques, pacing techniques, sleep hygiene techniques and depressive thinking self-management techniques. People who attend may be on many medications, may feel isolated, be living on benefits and have lost their ability to work. The group offers peer-support and self-management techniques.

Southwark IAPT also provides mindfulness-based cognitive therapy for people with medically unexplained symptoms or long-term conditions. This is an eight-week group programme aimed at helping patients to cope with their physical symptoms and associated stress, anxiety or depression.

An innovative weight management group intervention for people with anxiety or depression and a BMI of over 30 is provided by Southwark IAPT. Although obese individuals have higher rates of depression and anxiety, specific NHS interventions for people with such comorbidity is very unusual. The group follows standard NICE guidance on weight management interventions but also incorporates additional components to address comfort eating and to support the development of motivation and self-compassion, both of which can be difficult for people experiencing low mood and obesity. The group focuses on behaviour changes that lead to healthier habits and facilitates an average weight loss of 2.2kg, plus improvements in mood and eating behaviours.

Our commitment to the integration of physical and mental health care is further demonstrated by the decision to locate some Southwark IAPT therapists within King's College Hospital to help improve service accessibility for people with physical health conditions. The care pathway involving Southwark IAPT and the breast care unit at King's College Hospital was cited as an example of best practice in the NHS London Strategic Clinical Network's document (2015): "Psychological support for people living with cancer: Commissioning guidance for cancer care in London".²

The UPBEAT-UK programme

This research programme was funded by the NIHR and led by Professor André Tylee. The team conducted research with people on GP Coronary Heart Disease (CHD) registers in 33 south London practices to examine links between CHD, depression, anxiety and worse cardiac outcomes; and to develop and pilot personalised care by nurses for people with CHD suffering from chest pain and depression. We followed over 800 people with CHD for up to three years, assessing them for depression, chest pain and worsening of heart disease. We asked patients, GPs and nurses how people with CHD and depression should be treated. We developed personalised care (designed for each person) and tested it in 41 people (while 40 people received their usual care from GPs) with chest pain and depression to assess how acceptable it is, whether it helps and what the costs would be. Personalised care was acceptable to people and those who received it reported less chest pain after six and 12 months.

Just under half of people with CHD had chest pain. Depression was frequent, but anxiety was more common and increased the chances of both heart attacks and death. Further research is planned to more fully understand the links between anxiety, chest pain and heart disease

2 www.londonscn.nhs.uk/wp-content/uploads/2015/06/mh-cancer-commissioning-guide-062015.pdf

and to develop personalised care for use in primary care settings, including IAPT.

Tylee, A., Barley, E.A, Walters, P., Achilla, E., Borschmann, R., Leese, M., McCrone, P., Palacios, J., Smith, A., Simmonds, R., Rose, D., Murray, J., van Marwijk, H., Williams, P. & Mann, A. (2016). UPBEAT-UK: a programme of research into the relationship between coronary heart disease and depression in primary care patients. Programme Grants for Applied Research, No. 4.8. Southampton (UK): NIHR Journals Library. Available at: www.ncbi.nlm.nih.gov/books/NBK363081/

PROMPT (Predictors of Outcome following Psychological Therapy)

This study was launched in January 2014 in the Southwark Psychological Therapies Service to establish the necessary infrastructure for research to identify factors that predict positive or negative responses to first-line psychological therapies. Whilst first-line psychological treatments are effective for nearly half of attenders, there remain a substantial number of patients who do not benefit. For the first time, we are systematically collecting biological and clinical data from an IAPT population, which will allow us to look at biological predictors, including genetic profiles. This relates to Heggaul (2016) and Grant (2014).

We have successfully recruited and assessed approximately 350 participants using the new Clinical Research Facility. Participants are approached before starting treatment and offered a baseline interview to be carried out while they are waiting. Consenting participants complete a diagnostic interview, are asked to give blood and hair samples for relevant biomarkers and complete psychological and social questionnaire measures. They then go on to complete their psychological therapy as offered by the Southwark Psychological Therapies Service. Response to psychological therapy will be measured using standard IAPT outcome data, which are routinely collected at each appointment. This will allow us to test for relationships between predictor variables and patient outcome measures, with the goal of basing future clinical decision-making on the individual needs of the patient in an evidence-based manner. In addition, the identification of individuals who fail to improve following therapy delivered by IAPT services could inform the development of novel interventions.

PROMPT is funded by the NIHR Mental Health Biomedical Research Centre for Mental Health (BRC-MH) at the Institute of Psychiatry, Psychology and Neuroscience (IoPPN) and South London and Maudsley (SLaM) NHS Foundation Trust.

Heggul, N., King, S., Amarasinghe, M., Breen, G., Grant, N., Grey, N., Hotopf, M., Moran, P., Pariente, C.M., Tylee, A., Wingrove, J., Young, A.H. & Cleare, A.J. (2016) Clinical characteristics of patients assessed within an Improving Access to Psychological Therapies (IAPT) service: results from a naturalistic cohort study (Predicting Outcome

Following Psychological Therapy; PROMPT), BMC Psychiatry, 16 (1), 52. 10.1186/s12888-016-0736-6

Abstract

BACKGROUND: A substantial number of patients do not benefit from first line psychological therapies for the treatment of depression and anxiety. Currently, there are no clear predictors of treatment outcomes for these patients. The PROMPT project aims to establish an infrastructure platform for the identification of factors that predict outcomes following psychological treatment for depression and anxiety. Here we report on the first year of recruitment and describe the characteristics of our sample to date.

METHODS: One hundred and forty-seven patients awaiting treatment within an Improving Access to Psychological Therapies (IAPT) service were recruited between February 2014 and February 2015 (representing 48% of those eligible). Baseline assessments were conducted to collect information on a variety of clinical, psychological and social variables including a diagnostic interview using the Mini International Neuropsychiatric Interview (MINI).

RESULTS: Our initial findings showed that over a third of our sample were not presenting to IAPT services for the first time, and 63% had been allocated to receive higher intensity IAPT treatments. Approximately half (46%) were taking prescribed psychotropic medication (most frequently antidepressants). Co-morbidity was common: 72% of the sample met criteria for

2 or more current MINI diagnoses. Our initial data also indicated that 16% met criteria for borderline personality disorder and 69% were at high risk of personality disorder. Sixty-one percent scored above the screening threshold for bipolarity. Over half of participants (55%) reported experiencing at least one stressful life event in the previous 12 months, whilst 67% reported experiencing at least one form of childhood trauma.

Our results to date highlight the complex nature of patients seen within an urban IAPT service, with high rates of psychiatric comorbidity, personality disorder, bipolarity and childhood trauma. Whilst there are significant challenges associated with researching IAPT populations, we have also confirmed the feasibility of undertaking such research.

Research Excellence Framework 2014

The IoPPN achieved a remarkably positive performance in the Research Excellence Framework (REF) within Unit of Assessment (UoA) 4, Psychology, Psychiatry and Neuroscience, which accommodates the vast majority of our activity. Overall, 88% of our submission was rated 'world-leading' or 'internationally excellent' (4*/3*). Within this overall assessment, our research environment was given a 100% world-leading rating and the impact of our work was judged to be 100% world-leading or internationally excellent. The Institute submitted 257 staff (238 FTE) and in line

with our commitment to promoting women in science, 44% were women and 65 were early career researchers.



Developing research awareness and capability in MAP services

Since June 2014, each service is required to have a Research Link Worker whose role it is to:

- be the contact person for any researcher wanting to carry out a research project or audit
- ensure the clinical team know that any research or audit is happening and that its findings are communicated to the team
- raise awareness of wider research and audit in the team and feed any relevant discussions

or ideas back to the MAP CAG Research and Training Executive.

Research seminars were held in February and November 2015 for Research Link Workers and wider clinical staff to hear about current research and meet MAP research leads. Building on their success, we plan to hold regular seminars to foster ongoing communication of research needs and findings, and collaboration between clinicians and academics.

Surveys of staff research involvement were conducted in September 2014 (targeting MAP psychologists and psychotherapists) and November 2015 (across all clinical professions). The responses showed a desire to be more involved in research and that the majority would like support with:

- information about research occurring in MAP CAG
- opportunities to collaborate with more experienced researchers
- access to journals
- access to recent research summaries.

The **Research Link Worker** network will be used as a vehicle to identify and meet these needs.

We will also work to ensure that education and research are delivered in a seamless fashion across the SLAM/KCL boundary, and to develop shared training enterprises between the CAG and Departments/Divisions.

Which outcomes do we use?

Clinical Outcomes

Clinical outcomes are measurable changes in the health or quality of life of patients that result from the care they have received. **The constant review of clinical outcomes establishes standards against which we can continuously improve all aspects of clinical practice.**

Health of the Nation Outcome Scales (HONoS)

The Trust Clinical Outcomes Team is a UK leader, influencing the implementation of clinical outcomes measurement in secondary mental health services across England. The team make recommendations to the Department of Health on outcomes and Payment by Results policy

developments and assists other mental health Trusts with their outcomes implementation programmes. The SLaM Trust possesses an extensive outcomes dataset, developed over many years, which provides practice-based evidence of the clinical effectiveness of MAP CAG services.

Clinical Outcome in Routine Evaluation (CORE) Outcome Measure (CORE-OM)

The CORE-OM (Evans et al, 2000) is a generic self-report measure of global distress (GD), comprising 34 items including subscales relating to subjective well-being, commonly-experienced problems or symptoms, social/life functioning and risk to self and others. The measure is suitable for use as an initial screening tool and for assessing response

to psychological therapy across a wide range of service types and is used by SLaM MAP services.³

Figure 2 | CORE-OM Mean Threshold Scores

Mean Clinical Cut-Off Scores

(W) Subjective Well Being	1.57
(P) Problems or Symptoms	1.53
(F) Functioning	1.3
(R) Risk	0.37
Total Minus risk	1.24
Global Distress (Total)	1.43

Quality of care outcomes

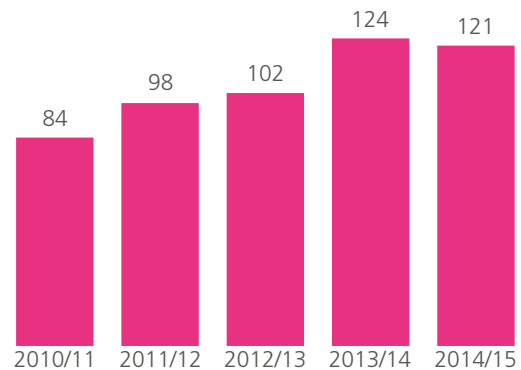
We aim to ensure that all patients get the most effective care in a timely and efficient manner. 'Quality of care' is a guiding principle in assessing how well the health system is performing in its mission to improve the health of patients. The quality of care outcomes we collect assess the health system's performance and measure how safe, effective, patient-centred, timely, efficient and equitable the care we provide is.

Level of complaints

One of our priority areas has been to review the number of complaints. The increase in complaints reflects a CAG drive to encourage

feedback. Patients told us that one of the barriers to this was lack of clarity about how to make complaints. The CAG has put a plan in place to address feedback and monitor all complaints both formal and informal.

Figure 3 | Showing the number of complaints over the last five years



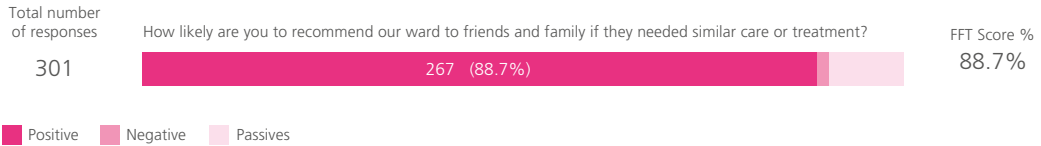
Patient experience

Collecting and analysing data about patients' experiences of healthcare is essential to achieving high quality care. Across King's Health Partners, we are committed to using patient experience data to improve the quality of the care we provide. Below is the current patient experience dashboard for the CAG for 2015/16 from SLaM's Patient Experience Data Intelligence Centre (PEDIC) showing the results for each quarter.

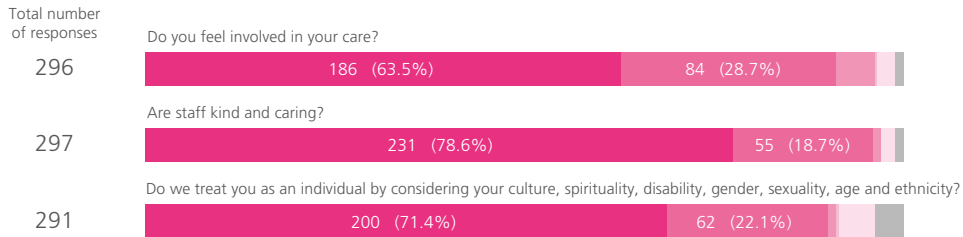
³ Evans, C. E., Mellor-Clark, J., Margison, F., et al (2000) Clinical Outcomes in Routine Evaluation: the CORE Outcome Measure (CORE-OM). *Journal of Mental Health*, 9, 247–255.

Figure 4 | 2015/16 Quarter 1 results for Question 1

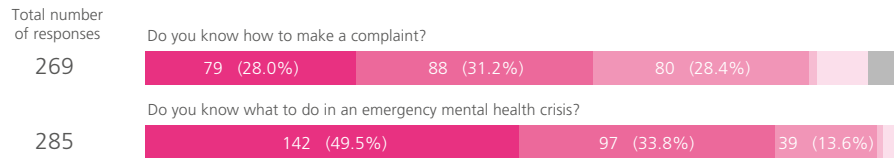
Friends and family test



Core questions



Community



Inpatient

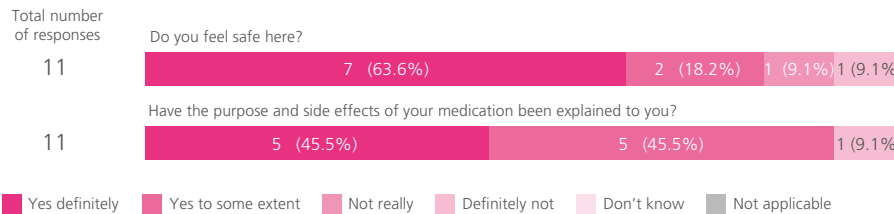
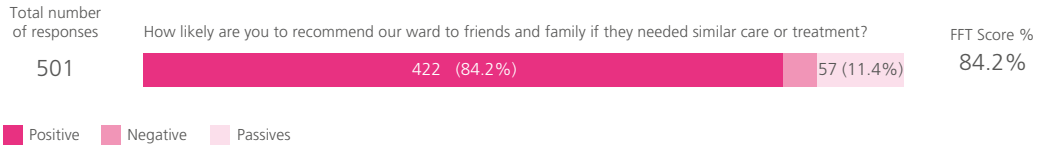
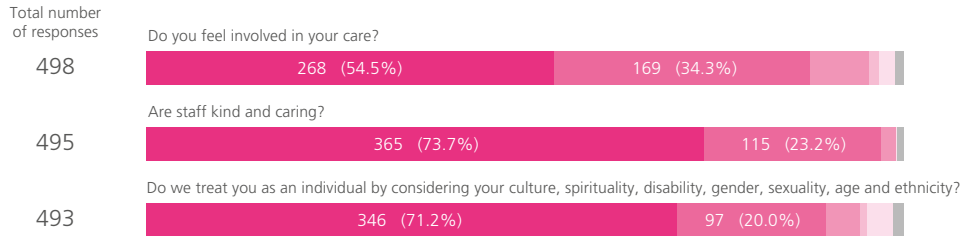


Figure 5 | 2015/16 Quarter 2 results for Question 1

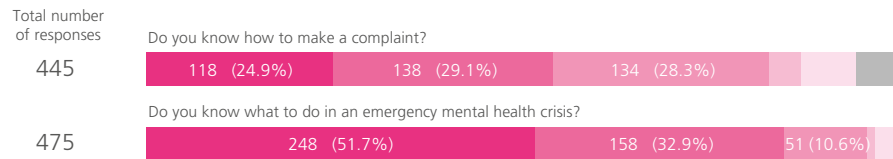
Friends and family test



Core questions



Community



Inpatient

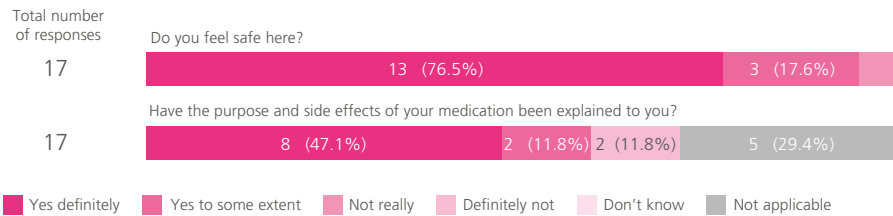
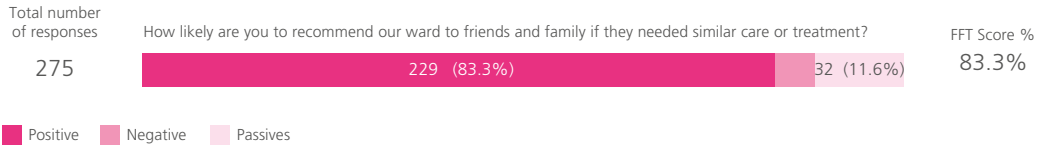
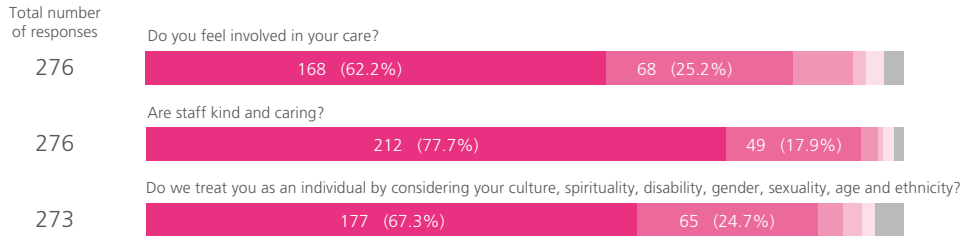


Figure 6 | 2015/16 Quarter 3 results for Question 1

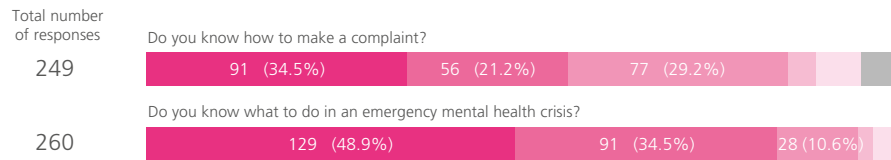
Friends and family test



Core questions



Community



Inpatient

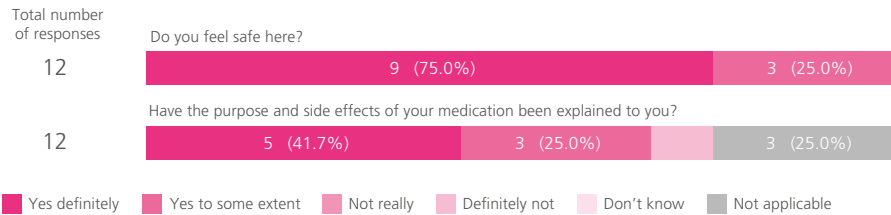
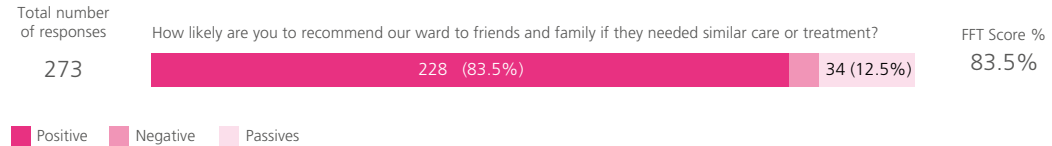
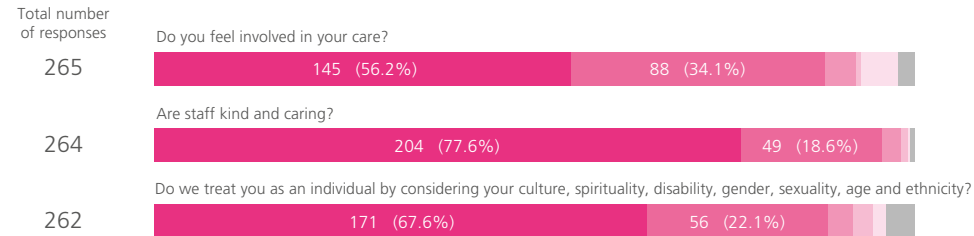


Figure 7 | 2015/16 Quarter 4 results for Question 1

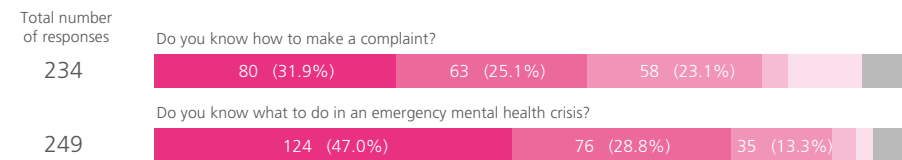
Friends and family test



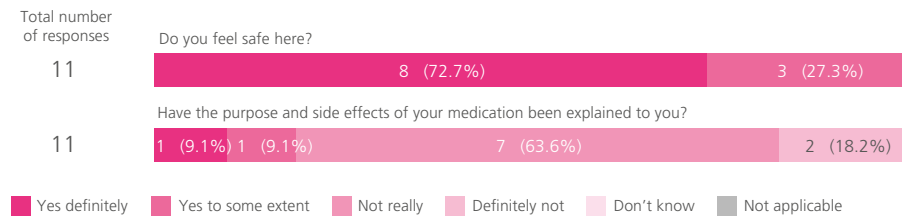
Core questions



Community



Inpatient





Anxiety
disorders

Anxiety care pathway

Anxiety Disorders services

Anxiety Disorders Residential Unit

We offer a cognitive behavioral therapy (CBT) service for treatment-resistant, anxiety-based problems, where people can stay in a residential unit throughout their treatment, making our service unique in the UK. Our inpatient service is especially designed for people with obsessive compulsive disorder (OCD), body dysmorphic disorder (BDD) and a specific phobia of vomiting. However, it can benefit people with all types of anxiety disorders. See www.national.slam.nhs.uk/adru.

Centre for Anxiety Disorders and Trauma (CADAT)

CADAT is an outpatient clinic which treats people whose main problem is an anxiety disorder, especially Obsessive Compulsive Disorder (OCD), including hoarding, Body Dysmorphic Disorder

(BDD), Post-Traumatic Stress Disorder (PTSD), Social Anxiety Disorder (SAD) Panic Disorder, and Specific Phobias. Many of the CBT treatments we offer have been developed by our own teams, have been shown to be extremely effective in randomised controlled trials and are subject to high levels of quality control. Our centre is a leader in both research and clinical treatment of anxiety in the UK, and is the main contributor to the research in anxiety disorders in our Clinical Academic Group (see www.kcl.ac.uk/cadat).

CADAT see people within primary, secondary and tertiary care. CADAT forms a part of each of Lambeth, Southwark and Lewisham Improving Access to Psychological Therapies (IAPT) services and each borough's secondary care psychological therapies teams (IPTTs). CADAT also accepts referrals nationally (www.national.slam.nhs.uk/cadat). CADAT holds a Highly Specialised Service contract with NHS England to provide treatment for people with OCD and BDD who have not improved or sustained their improvement with previous treatment. All CADAT therapists are accredited CBT practitioners and many are accredited CBT supervisors and trainers.

CADAT also provides specialist training and supervision within local MAP CAG services, more widely within SLAM and on established training courses, especially the PgDip in CBT based at the Institute of Psychiatry, Psychology and Neuroscience (IoPPN).



Improving Access to Psychological Therapies (IAPT)

There are Improving Access to Psychological Therapies (IAPT) services provided in each of the boroughs of Lambeth, Lewisham, Croydon and Southwark. They provide advice and brief treatment, including self-help therapy for people aged over-18 with depression or anxiety. A particular focus of the service is caring for people who are unemployed or who are at risk of losing their job. For more details see www.slam-iapt.nhs.uk.

Traumatic Stress Service

The Traumatic Stress Service (TSS) is the only national NHS service offering second opinions and new forms of treatment for patients with complex presentations, including dissociative disorders, trauma and psychosis and personality difficulties secondary to adult or developmental trauma. See www.national.slam.nhs.uk/traumaticstress.

The service offers an integrated and culturally-sensitive approach to treatment where patients are provided with a treatment programme tailored to their cultural and linguistic needs, as well as to the complexity of their symptoms. Clinical work is supervised, measured and audited.

The aim is for patients to develop a sense of control and to support healthy boundary development. We achieve this through a variety of modalities of treatment, using a tailor-made programme devised for each patient.

Description of service

The anxiety care pathways cover numerous clinical pathways for different diagnoses of anxiety and related disorders, as well as complex co-morbid conditions in which anxiety forms a significant aspect. The diagnoses covered include Panic Disorder, Specific Phobia, Generalized Anxiety Disorder (GAD), Social Anxiety Disorder, Post Traumatic Stress Disorder (PTSD), Obsessive-Compulsive Disorder (OCD), Body Dysmorphic

Disorder (BDD), Hoarding Disorder, and Hypochondriasis (Health Anxiety). The most recommended first line treatment for anxiety disorders is cognitive behavioural therapy (CBT).

MAP CAG services that provide care and treatment within the anxiety care pathway are the primary care Improving Access to Psychological Therapy (IAPT) services across the four SLaM boroughs, the secondary care Integrated Psychological

Therapies Teams (IPTT) and Community Treatment Teams.

In addition, the CAG has three specialist services focusing on anxiety and related disorders: the Anxiety Disorders Residential Unit (ADRU), the Centre for Anxiety Disorders and Trauma (CADAT) and the Traumatic Stress Service (TSS).

Current MAP CAG anxiety care pathways:

Service	Treatment	
Improving Access to Psychological Therapies (IAPT) Services	Step 2 (Low Intensity treatment): CBT-based guided self-help for many anxiety diagnoses from Psychological Wellbeing Practitioners	Step 3 (High Intensity treatment): CBT for all diagnoses (and potentially EMDR for PTSD) from High Intensity Therapists
Integrated Psychological Therapies Teams (IPTT)	Wider range of psychotherapies: greater complexity and patient choice	
MAP teams (CMHTs)	See many people with anxiety, often in context of wider issues and other diagnoses	

MAP CAG anxiety care pathways for specialist services:

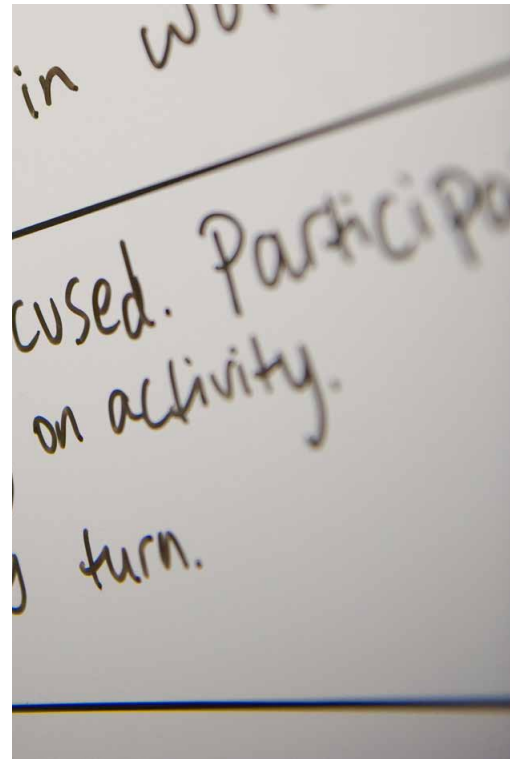
Service	Treatments	Level of care	Referral route
Centre for Anxiety Disorders and Trauma (CADAT)	Outpatient CBT for all anxiety disorders	Primary and secondary	Through IAPT and IPTT
CADAT		Tertiary/National	CCG funding panel for all disorders, or NHSE funding for Highly Specialised Services for people with treatment refractory OCD/BDD
Anxiety Disorders Residential Unit (ADRU)	Inpatient CBT especially for OCD/BDD	Tertiary/National	CCG funding panel for all disorders, or NHSE funding for Highly Specialised Services for people with treatment refractory OCD/BDD
Traumatic Stress Service (TSS)	Outpatient: for people with PTSD (especially dissociative sub-type)	Tertiary/National	CCG funding panel

Anxiety Care Pathway Working Groups

There was a day-long stakeholder workshop in September 2014 focused on developing anxiety care pathways. From this, we have established further working group meetings on 'trauma & PTSD', 'hoarding disorder' and 'severe agoraphobia'. We have established local 'trauma leads' in each service to map provision, disseminate information and develop clinical guidance for the PTSD pathway.

For the hoarding pathway, we are working with local authorities and others to establish a coordinated response, including seeking funds for specific new projects. For the agoraphobia pathway, we have established basic principles underpinning provision.

Ongoing CBT supervision and training from CADAT staff alongside others is being established in the Recurrent Affective Disorders. **An anxiety e-learning package was made available in early 2016 on the KHP Learning Hub.** We plan to benchmark effectiveness for specific anxiety disorders across the SLaM IAPT services to share best practice.



Activity

Figure 8 | Showing the number of accepted referrals to the Anxiety Disorders Residential Unit – Inpatient over the last three years

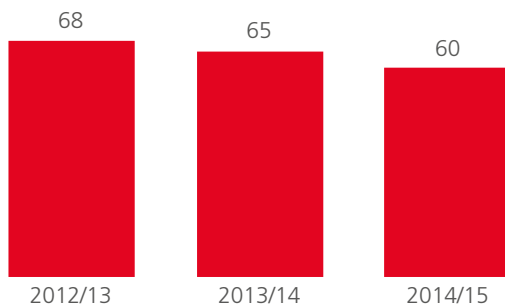
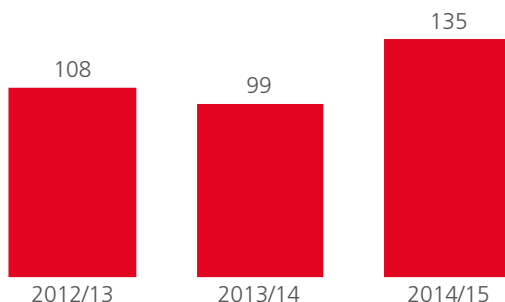


Figure 9 | Showing the number of accepted referrals to the Anxiety Disorders Residential Unit – Outpatient and follow-up service over the last three years



The two charts above show that inpatient numbers have decreased slightly and outpatient numbers have increased, showing improvement in patient flow, in keeping patients out of inpatient

services and maintaining them better via more outpatient services.

The out-patient assessment and follow up service has continued to manage increasing demand offering a viable treatment option for many individuals with treatment resistant disorders. It provides an alternative treatment environment for those who do not require inpatient care, but will benefit from the residential treatment and support of a compassionate community.

In terms of our treatment response rates, 90% of clients made a full response, 5% made a partial response, and 5% made no response (a full response equates to a 35% reduction in symptoms [OCD] and a 30% reduction in symptoms [BDD]). There was a mean overall improvement in Yale-Brown Obsessive Compulsive Scale score of 17 (s.d. 7.6) for OCD. This is, on average, a 53% reduction in symptoms. For BDD there was a mean improvement of 28 (s.d. 2.7) on the YBOCS. This equates to a 68% reduction in symptoms.

Residents are invited to complete a satisfaction survey at the end of their treatment. There was a mean overall satisfaction rating of 4.42 (scored 1–5 with 5 indicative of higher satisfaction). Residents were also asked whether they would recommend the unit and the mean recommendation score was 4.85 (scored 1–5 with 5 indicative of more likely to recommend to others).

Residents were also invited to make comments as to ways in which the service could be improved.

Below is a sample of comments.

All the therapists, occupational therapists, assistant therapists and support staff work together as a seamless team. They are all supportive, highly motivated and committed to help you to change. They treat patients with the respect they would wish to be treated with.

Keep on doing what you are doing.

From my first session I felt listened to and understood. I was treated with respect, dignity and non-judgment from my therapist.

The therapist travelled to my home and helped me apply what I had learned in the unit.

The service has been working to introduce the idea of “therapy in action” to help clients take what they have learnt in an individual therapy session and apply it in a range of different environments – such as their home, occupational therapy, voluntary work and study. The overall aim is to smooth the transition between treatment and discharge. A compassionate mind group is being developed as an adjunct to cognitive behavioral therapy, and to encourage the residents to show compassion to one another.

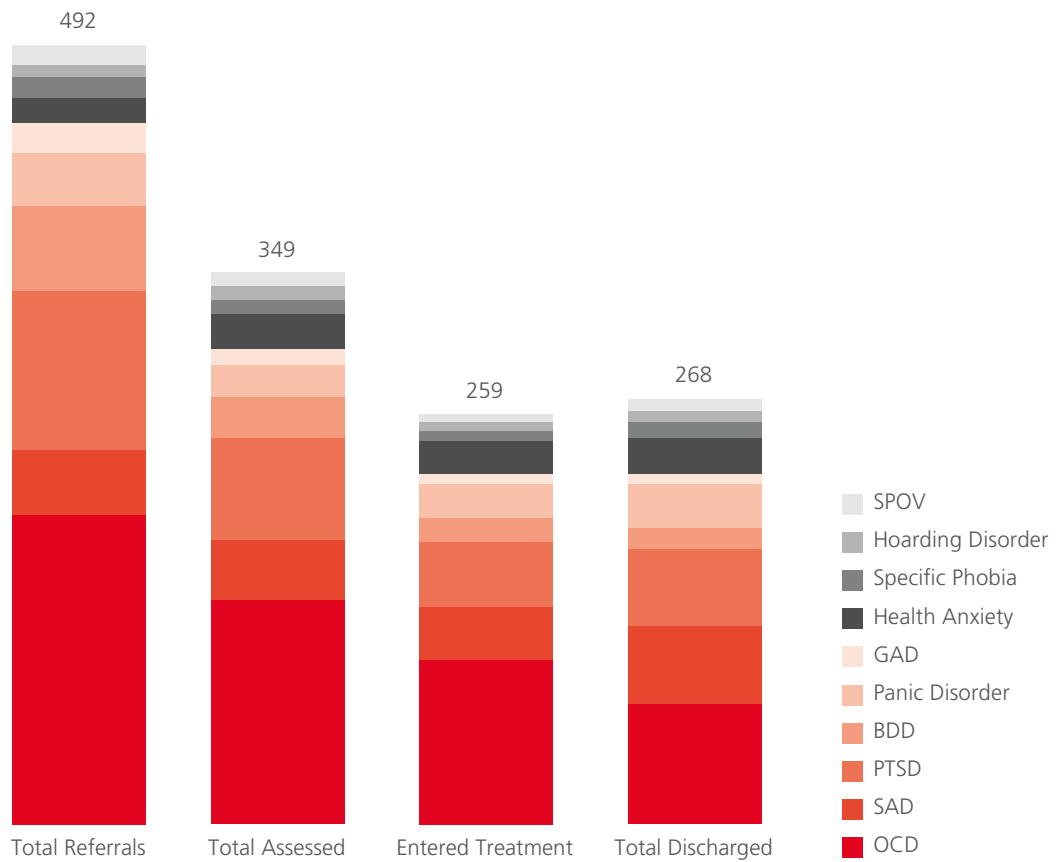
Following a focus group with service users and staff a treatment protocol for the Specific Phobia of Vomiting has been developed, introducing the

use of virtual reality to try and improve outcomes by providing an immersive experience for clients. The service has secured a small grant and is in the process of running a case series to look at the acceptability of virtual reality as an adjunct to usual treatment.

Centre for Anxiety Disorders and Trauma: number of referrals into service by diagnosis

The largest number of referrals into the clinic in 2015/6 were for OCD, with PTSD and then BDD referrals being the next most prevalent. [Total discharges include those discharged pre and post assessment. Scheduled and unscheduled discharges are from those who started treatment.]

Figure 10 | CADAT referrals 2015/16



Clinical outcomes

Figure 11 | Treatment results for patients treated by the Centre for Anxiety Disorders and Trauma

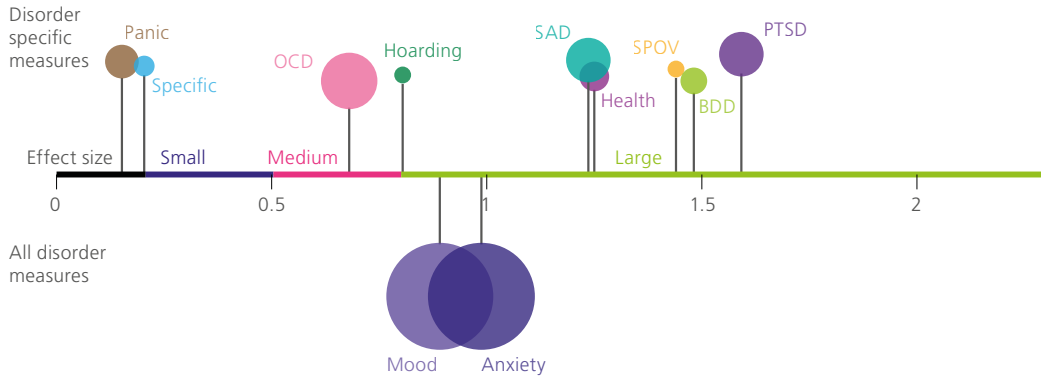
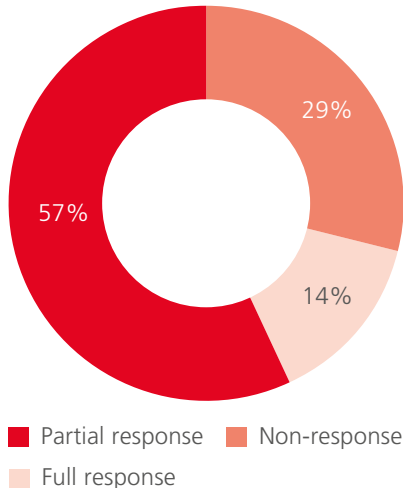


Figure 11 lists the outcomes by diagnosis for all patients treated at the Centre for Anxiety Disorders and Trauma in 2015/6. The graph shows effect sizes (how well people did in treatment) from left to right i.e. the further right a diagnosis is on the chart, the better patients with this diagnosis did in treatment. Most effects sizes for problems treated at the clinic were either medium or large. The larger the circle, the higher the number of patients with that diagnosis. The balloons on the top of the chart show how well patients did on specific measures designed to report their symptoms. The balloons on the bottom of the chart show how well they did on more general measures of improvements to mood and anxiety.

Figure 12 | Treatment results for patients seen at CADAT, with treatment resistant OCD or BDD which had not responded to past treatments at other clinics



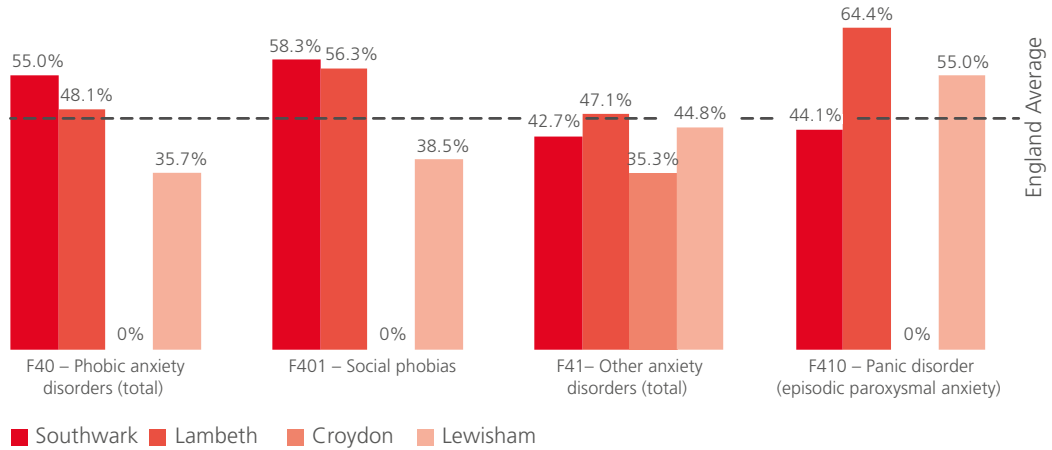
71% of patients with severe and longstanding OCD or BDD made either partial or full response to treatment through the clinic. This is an excellent result for a group of patients with severe and disabling anxiety.

Most people with anxiety disorders in the MAP CAG are treated within SLaM's four IAPT services: Lambeth, Southwark, Lewisham and Croydon (www.slam-iapt.nhs.uk). The data below is taken from publicly available data for these services.

Number of referrals per year	Total number of referrals
Southwark Psychological Therapies Service (Southwark IAPT)	6,760
Lewisham Psychological Therapies Service (Lewisham IAPT)	5,655
Croydon Psychological Therapies Service (Croydon IAPT)	3,290
Lambeth Psychological Therapies Service (Lambeth IAPT)	7,780

IAPT services throughout England use the same outcome measures and are tasked to meet certain 'recovery rates'. A person is said to have 'recovered' if they move from pre-defined 'caseness' on the PHQ-9 (a measure of low mood) or the GAD-7 (a measure of anxiety) to 'non-caseness' on *both* these measures. The national target is to move towards 50% recovery.

Figure 13 | Showing percentage recovery rates for SLAM IAPT services for anxiety disorders (2014)



There is very little recovery rate data for Croydon because the service started later than the others.

The recovery rates are mostly approaching the national targets. There are differences across disorders and across services, which indicates the need for the planned benchmarking (across SLAM) and sharing of best practice.

Patient experience quotes

I would like to say a massive thank you to all of the staff for enabling me to get my life back and allowing me to be able to do things I have not managed for many years.

I am leaving the unit so empowered and ready to keep fighting.

She has been fantastic; she has given me time, patience, and excellent understanding of my disorder and has enabled me to regain my confidence and life, for this I am eternally grateful.

Living with other people helped me combat my fears of contamination.

I felt supported all the time and was impressed by the level of flexibility showed by the therapists my quality of life has definitely improved.

Supportive and accessible, approachable and don't make you feel rushed even though NHS is under a lot of pressure, especially mental health parts.

I found the psychologist to be clear and professional and understanding without being patronizing and the process of being seen by them was easy and pretty efficient.

Great service, professional and considerate.

The treatment I received has been very helpful and has had a significant positive impact on my life. The psychologists I worked with struck me as genuine, devoted and caring people who were passionate about their jobs and about helping others.

Research and innovations in this care pathway

CADAT

Dr Blake Stobie and Dr David Veale co-direct CADAT, which conducts research alongside its routine NHS clinical service. CADAT has helped to develop cognitive behavioural therapies for anxiety and related disorders. These have been shown to be effective both in controlled trials and in routine services.

They have formed an important part of the NICE guidelines for treatments for anxiety disorders, all of which have CBT as the recommended first line treatment. CADAT's research includes: randomised controlled trials (RCT) examining the effectiveness of new treatments and modes of treatment delivery; observational studies investigating the phenomenology and correlates of anxiety disorder, such as the relationship between sleep problems

and PTSD; theoretical and basic science studies examining underlying cognitive processes such as attentional and interpretation biases; and service evaluation projects and audits.

Focus of research

Body Dysmorphic Disorder

The first trial worldwide comparing cognitive behavioural therapy (CBT) for Body Dysmorphic Disorder (BDD) with another active treatment was recently completed at CADAT. Led by Dr David Veale, this has shown the efficacy of CBT for BDD.

Veale, D., Anson, M., Miles, S., Pieta, M., Costa, A., Ellison, N. (2014). Efficacy of cognitive behaviour therapy versus anxiety management for body dysmorphic disorder: A randomised controlled trial. Psychotherapy and Psychosomatics. 83(6): 341–353.

Background: The evidence base for the efficacy of cognitive behaviour therapy (CBT) for treating body dysmorphic disorder (BDD) is weak.

Aims: To determine whether CBT is more effective than anxiety management (AM) in an outpatient setting.

Method: This was a single-blind stratified parallel group randomised controlled trial. The primary endpoint was at 12 weeks, and the Yale-Brown Obsessive Compulsive Scale for BDD (BDD-YBOCS) was the primary outcome measure. Secondary measures for BDD included the Brown Assessment of Beliefs Scale (BABS), the Appearance Anxiety

Inventory (AAI) and the Body Image Quality of Life Inventory (BIQLI). The outcome measures were collected at baseline and week 12. The CBT group, unlike the AM group, had 4 further weekly sessions that were analysed for their added value. Both groups then completed measures at their 1-month follow-up. Forty-six participants with a DSM-IV diagnosis of BDD, including those with delusional BDD, were randomly allocated to either CBT or AM.

Results: At 12 weeks, CBT was found to be significantly superior to AM on the BDD-YBOCS [$\beta = -7.19$; SE (β) = 2.61; $p < 0.01$; 95% CI = -12.31 to -2.07; $d = 0.99$] as well as the secondary outcome measures of the BABS, AAI and BIQLI. Further benefits occurred by week 16 within the CBT group. There were no differences in outcome for those with delusional BDD or depression.

Conclusions: CBT is an effective intervention for people with BDD even with delusional beliefs or depression and is more effective than AM over 12 weeks.

Post-traumatic Stress Disorder and Social Anxiety Disorder

CADAT and the Psychology Department at IoPPN have an ongoing collaboration with the Wellcome Trust Anxiety Disorders Group led by Professors Ehlers and Clark at Oxford University. The research focuses on making cognitive therapy treatments for Social Anxiety Disorder and Post Traumatic Stress Disorder more efficient and widely-accessible. This has included the development and evaluation of brief treatments, aided by

self-help materials, intensive treatments and internet treatments, all of which widen access and increase patient choice. A recent RCT has demonstrated the effectiveness of a therapist-supported internet cognitive therapy for social anxiety disorder.

The next stage of the research will be investigating how best to disseminate this treatment to IAPT services. This work will start with the SLaM-run IAPT services which have helped support this research. For treatment of PTSD, two recent RCTs have shown the effectiveness of an intensive treatment in which the sessions are mostly conducted within one week rather than more than three months, and a brief treatment supported with self-help materials in which the total therapist time is significantly reduced. A new internet treatment for PTSD is being developed.

Ehlers, A., Hackmann, A., Grey, N., Wild, J., Liness, S., Albert, I., Deale, A., Stott, R., Clark, D.M. (2014). A randomized controlled trial of 7-day intensive and standard weekly cognitive therapy for PTSD and emotion-focused supportive therapy, American Journal of Psychiatry, 171 (3): 294–304.

Objective: Psychological treatments for post-traumatic stress disorder (PTSD) are usually delivered once or twice a week over several months. It is unclear whether they can be successfully delivered over a shorter period of time. This clinical trial had two goals: to investigate the acceptability and efficacy of a 7-day intensive version of cognitive therapy for PTSD and to investigate whether cognitive therapy has specific

treatment effects by comparing intensive and standard weekly cognitive therapy with an equally credible alternative treatment.

Method: Patients with chronic PTSD (N=121) were randomly allocated to 7-day intensive cognitive therapy for PTSD, 3 months of standard weekly cognitive therapy, 3 months of weekly emotion-focused supportive therapy, or a 14-week waiting list condition. The primary outcomes were change in PTSD symptoms and diagnosis as measured by independent assessor ratings and self-report. The secondary outcomes were change in disability, anxiety, depression, and quality of life. Evaluations were conducted at the baseline assessment and at 6 and 14 weeks (the posttreatment/ wait assessment). For groups receiving treatment, evaluations were also conducted at 3 weeks and follow-up assessments at 27 and 40 weeks after randomization. All analyses were intent-to-treat.

Results: At the posttreatment/wait assessment, 73% of the intensive cognitive therapy group, 77% of the standard cognitive therapy group, 43% of the supportive therapy group, and 7% of the waiting list group had recovered from PTSD. All treatments were well tolerated and were superior to waiting list on nearly all outcome measures; no difference was observed between supportive therapy and waiting list on quality of life. For primary outcomes, disability, and general anxiety, intensive and standard cognitive therapy were superior to supportive therapy. Intensive cognitive therapy achieved faster symptom reduction and comparable overall outcomes to standard cognitive therapy.

Conclusions: Cognitive therapy for PTSD delivered intensively over little more than a week was as effective as cognitive therapy delivered over 3 months. Both had specific effects and were superior to supportive therapy. Intensive cognitive therapy for PTSD is a feasible and promising alternative to traditional weekly treatment.

Stott, R., Wild, J., Grey, N., Liness, S., Warnock-Parkes, E., Commins, S., Readings, J., Bremner, G., Woodward, E., Ehlers, A., Clark, D.M. (2013). Internet-delivered cognitive therapy for social anxiety disorder: A development pilot series. Behavioural and Cognitive Psychotherapy, 41 (4): 383–397.

Background: Randomized controlled trials have established that individual cognitive therapy based on the Clark and Wells (1995) model is an effective treatment for social anxiety disorder that is superior to a range of alternative psychological and pharmacological interventions. Normally the treatment involves up to 14 weekly face-to-face therapy sessions.

Aim: To develop an internet based version of the treatment that requires less therapist time.

Method: An internet-delivered version of cognitive therapy (iCT) for social anxiety disorder is described. The internet-version implements all key features of the face-to-face treatment; including video feedback, attention training, behavioural experiments, and memory focused techniques. Therapist support is via a built-in secure messaging system and by brief telephone calls. A cohort of 11 patients meeting DSM-IV criteria

for social anxiety disorder worked through the programme and were assessed at pretreatment and posttreatment.

Results: No patients dropped out. Improvements in social anxiety and related process variables were within the range of those observed in randomized controlled trials of face-to-face CT. Nine patients (82%) were classified as treatment responders and seven (64%) achieved remission status. Therapist time per patient was only 20% of that in face-to-face CT.

Conclusions: ICT shows promise as a way of reducing therapist time without compromising efficacy. Further evaluation of iCT is ongoing.

Generalised Anxiety Disorder

Dr Colette Hirsch leads the Cognition in Emotional Disorders and Resilience (CEDAR) team at King's College London and CADAT. She has developed and published a new model of Generalized Anxiety Disorder (GAD). Her team continue to conduct experimental psychology studies investigating aspects of this model and evaluating the novel CBT treatment derived from it. Research into cognitive biases in anxiety could lead to more personalised treatments for people with GAD. She was awarded a prestigious three-year MQ Impact award in early 2015 to continue this work. The impact is PsyIMPACT is MQ's flagship research initiative to support improvements in psychological treatments. It's a grant from new research charity MQ: Transforming Mental Health

Hirsch, C.R., Mathews, A., Lequertier, B., Perman, G., Hayes, S. (2013). Characteristics of worry in Generalized Anxiety Disorder. *Journal of Behavior Therapy and Experimental Psychiatry*, 44 (4): 388–395.

Background and objectives: Groups of clients and community volunteers with Generalized Anxiety Disorder (GAD) and clients with Panic Disorder were compared to a group with elevated worry but without GAD on a range of measures, to identify individual differences beyond a high propensity to worry.

Method: Participants completed standardised questionnaires and a behavioural worry task that assesses frequency and severity of negative thought intrusions.

Results: Relative to high worriers, clients with GAD had higher scores on trait anxiety, depression, more negative beliefs about worry, a greater range of worry topics, and more frequent and severe negative thought intrusions. Relative to community volunteers with GAD, clients in treatment reported poorer attentional control. Compared to clients with Panic Disorder, clients with GAD had higher trait anxiety, propensity to worry, negative beliefs and a wider range of worry content.

Conclusions: Results confirmed expectations of group differences based on GAD diagnostic criteria, but also revealed other differences in mood, characteristics of worry, and perceived attentional control that may play a role in the decision to seek treatment.

Obsessive Compulsive Disorder

Staff at CADAT have developed and demonstrated the effectiveness of an intensive form of Cognitive Behavioural Therapy (CBT) for Obsessive Compulsive Disorder OCD in which the treatment is offered within a week or two rather than over three to six months. Dr Fiona Challacombe has recently completed the first trial worldwide of intensive CBT for perinatal OCD (i.e. women who are experiencing OCD during pregnancy or during the first postnatal year). This has led to CADAT now offering this treatment both locally and nationally.

Challacombe, F.L., Salkovskis, P.M. (2011). *Intensive cognitive-behavioural treatment for women with postnatal obsessive-compulsive disorder: A consecutive case series. Behaviour Research and Therapy*, 49 (6–7): 422–426.

The postnatal period has been identified as a time of increased risk for the development of OCD. Obsessions and compulsions at this time frequently focus on accidental or deliberate harm coming to the infant and may impact on the sufferer's capacities as a parent. Given the similarities in presentation between OCD at this and other times, CBT is likely to be effective, but there is little information on whether or how adaptations of CBT can be made to maximise effectiveness and acceptability for mothers. There are no data on the impact of successful treatment on parenting. Six consecutively referred cases of postnatal OCD were treated using CBT intensively delivered over a two week period. All mothers improved on self-report and clinician-rated

measures which were sustained at 3–5 month follow-up. Mothers reported significant benefits in terms of their own symptoms and in parenting in general. The intensive mode of delivery appears to be effective and acceptable for this group. Future work should explore whether particular difficulties in terms of parenting are experienced by this group and whether these persist beyond the remission of the maternal disorder.

Hoarding Disorder

With the recent recognition of the diagnosis of Hoarding Disorder, Dr Victoria Bream and colleagues at CADAT are developing further treatments for such problems and starting to evaluate their effectiveness. The CAG also builds on the work of Professor Paul Salkovskis' (at KCL until 2011), who specialised in cognitive, behavioural and biological processes in the understanding and treatment of anxiety-related problems (including obsessive-compulsive problems, panic, phobias, health anxiety/hypochondriasis).

Tyrer, P., Cooper, S., Salkovskis, P., Tyrer, H., Crawford, M., Byford, S., Dupont, S., Finnis, S., Green, J., McLaren, E., Murphy, D., Reid, S., Smith, G., Wang, D., Warwick, H., Petkova, H., Barrett, B. (2014). Clinical and cost-effectiveness of cognitive behaviour therapy for health anxiety in medical patients: A multicentre randomised controlled trial. The Lancet, 383 (9913): 219–225.

Background: Health anxiety has been treated by therapist's expert in cognitive behaviour therapy with some specific benefit in some patients

referred to psychological services. Those in hospital care have been less often investigated. Following a pilot trial suggesting efficacy we carried out a randomised study in hospital medical clinics.

Methods: We undertook a multicentre, randomised trial on health anxious patients attending cardiac, endocrine, gastroenterological, neurological, and respiratory medicine clinics in secondary care. We included those aged 16–75 years, who satisfied the criteria for excessive health anxiety, and were resident in the area covered by the hospital, were not under investigation for new pathology or too medically unwell to take part. We used a computer generated random scheme to allocate eligible medical patients to an active treatment group of five-to-ten sessions of adapted cognitive behaviour therapy (CBT-HA group) delivered by hospital-based therapists or to standard care in the clinics. The primary outcome was change in health anxiety symptoms measured by the Health Anxiety Inventory at 1 year and the main secondary hypothesis was equivalence of total health and social care costs over 2 years, with an equivalence margin of 150. Analysis was by intention to treat. The study is registered with controlled-trials.com, ISRCTN14565822.

Findings: Of 28 991 patients screened, 444 were randomly assigned to receive either adapted cognitive behaviour therapy (CBT-HA group, 219 participants) or standard care (standard care group, 225), with 205 participants in the CBT-HA group and 212 in the standard care group included in the analyses of the primary endpoints. At 1 year, improvement in health anxiety in the patients in the CBT-HA group was 2.98 points

greater than in those in the standard care group (95% CI 1.64–4.33, $p=0.0001$), and twice as many patients receiving cognitive behaviour therapy achieved normal levels of health anxiety compared with those in the control group (13.9% vs 7.3%; odds ratio 2.15, 95% CI 1.09–4.23, $p=0.0273$). Similar differences were observed at 6 months and 2 years, and there were concomitant reductions in generalised anxiety and, to a lesser extent, depression. Of nine deaths, six were in the control group; all were due to pre-existing illness. Social functioning or health-related quality of life did not differ significantly between groups. Equivalence in total 2-year costs was not achieved, but the difference was not significant (adjusted mean difference 156, 95% CI -1446 to 1758, $p=0.848$).

Interpretation: This form of adapted cognitive behaviour therapy for health anxiety led to sustained symptomatic benefit over 2 years, with no significant effect on total costs. It deserves wider application in medical care.



Recurrent
affective
disorders

Recurrent affective disorders

Recurrent Affective Disorders Care Pathway

Community Treatment

The Community Treatment service is a multi-professional community team that offers psychological and pharmacological therapy interventions, alongside key working and dual diagnosis working, to people with complex non-psychotic presentations. These are primarily but not exclusively: recurrent affective disorders, anxiety, trauma, PTSD and OCD and personality disorders.

The treatment service offers all elements of an Assessment and Liaison service as described on page 92 combined with targeted therapeutic interventions either provided within the team or by co-working with Integrated Psychological Therapy Team (IPTT).

The service retains the ability to carry out Mental Health Act and Mental Capacity Act assessments, carers' assessment and to fulfil the safeguarding responsibilities, as well as liaising with local authority personalisation services.

The service has clinical specialists providing therapy, key working, clinical supervision and training to case managers in the community.

Integrated Psychological Therapy Team (IPTT)

This is a specialist psychological therapy service (secondary care) that provides assessment, care and treatment for people aged 18–65 who have a severe mental illness (across Lambeth, Lewisham, Croydon and Southwark boroughs).

Affective Disorders Intensive Treatment Service (OPTIMA)

In bipolar disorder, the period immediately following an affective episode is an important opportunity to optimise treatment and to prevent recurrence and re-admission. It is a period of high-risk for episode recurrence and for suicide.

OPTIMA Mood Disorders is an innovative new programme which will provide intensive outpatient treatment, constituting enhanced secondary/tertiary care for those recovering from mania or depression. This programme is an early initiative in the development of the Recurrent Affective Disorders Pathway, a partnership between Trust clinicians and the Centre for Affective Disorders established at the IOPPN in 2013.

An initial 18-month audit of this pilot service is in underway. It aims to assess the outcome of the 12-week core programme (expert pharmacotherapy and related treatments, specialist nursing, occupational therapy and elements of psychoeducation) and the effectiveness of key components.

Quantitative outcome data, comparing patient experiences before and after the programme, will be collected and analysed. Measures used will include the mean time between admissions, time between home treatment team episodes, numbers using self-management and crisis planning, numbers with unaddressed medical needs, numbers with improved concordance

with medication, numbers demonstrating improved quality of life and function, and numbers of completed carers' assessments.

National Affective Disorders Service

Our service provides specialist assessment and treatment for people with complicated or treatment-resistant affective disorders, including depression and bipolar disorder. Our team has an impressive record in treating those who have been previously resistant to treatment.

We offer a range of care options, depending on the needs of the person and the referrer: both benefit from the comprehensive specialist input delivered by internationally-recognised experts and their teams, with access to the latest evidence-based treatments.

We provide treatment and care to people locally and nationally who experience mood, anxiety or personality difficulties.

Clinical outcomes

Affective Disorders Intensive Treatments Service OPTIMA

The OPTIMA Mood Disorders Service is a newly-developed day treatment service for patients with bipolar disorder. Currently, the service is open to people from the Psychosis, MAP and Psychological

Medicine CAGs resident in Lambeth and Lewisham. The OPTIMA Mood Disorders Service is modelled on a Danish Specialist Mood Disorders Clinic which has been shown to reduce the risk of episode recurrence and re-admission in patients recently discharged from hospital.

The OPTIMA Core Programme, which started receiving referrals in May 2015, is designed to consolidate early recovery in frequently-admitted patients who have been recently discharged from hospital. The aim is to reduce the severity and frequency of subsequent relapses by facilitating understanding and self-management of the illness. Service users received multi-disciplinary interventions from psychiatrists, nurses and occupational therapists. Practical techniques to monitor mood, to identify episode triggers and early warning signs of recurrence are taught. Service users build a highly personalised resource folder, which includes their own recovery and support plan with detailed relapse and crisis management strategies.

The maintenance programme, which opened in Autumn 2015, is for people who have recovered but wish to reflect on and learn from their experiences through group psycho-education.

Clinical outcomes to be assessed before and after the core programme

1. 'time to next admission' compared to the mean length of previous inter-admission periods
2. Home Treatment Team contacts
3. medication concordance

4. unmet medical need
5. use of self-management techniques
6. level of functioning
7. quality of life
8. PEDIC and whether a carer's assessment has been completed.

Tertiary Affective Disorders Service

An audit is currently underway to assess referrer satisfaction. In addition to asking for descriptive feedback on the quality of the service and whether the service user was helped, this audit rates the following domains: quality and speed of verbal/written and e-mail communication, the quality of the assessment report, the quality and practicality of the suggested care plans, the ease with which tertiary service contracts and payments could be set up and the ease of making a referral. With regard to service user feedback, we have recently established service-specific PEDIC questions. This survey will be operational shortly.

Integrated Psychological Therapies Team (IPTT)

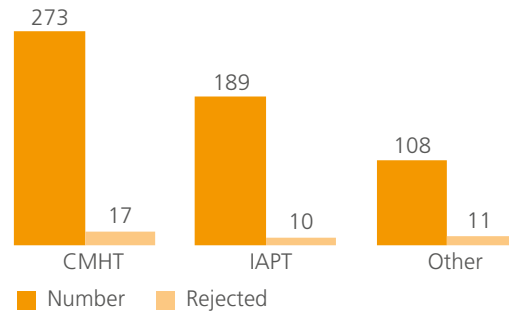
The service is operated across four boroughs (Lambeth, Lewisham, Southwark, and Croydon) and offers psychological therapy services in a range of modalities for services users with moderate to severe mental health problems. The IPTTs were set up in September 2012 when existing services were reconfigured.

Lambeth

Staff in Lambeth IPTT have worked hard at developing a creative working culture that puts those who need our services at the heart of what we do. To that end, we are continuously seeking to examine our practice, ensuring that what we offer is in line with the current evidence both from NICE and elsewhere. In Lambeth, the development of the Adult Mental Health (AMH) model continues to influence how we provide services. IPTT psychologists continue to provide consultation and joint assessments in line with what the teams need. As well as family therapy we will shortly be offering Myer-Briggs Type Indicator (MBTi) to service users.

Most assessments offered are general assessments, which are carried out by psychotherapists who normally offer Cognitive Analytic therapy (CAT), individual psychodynamic and group psychodynamic therapy. Other assessments are for MBT, Family and Couples therapy, Trauma and CBT psychology. Patients are then placed on the appropriate waiting list for the modality recommended.

Figure 14 | Activity numbers from September 2013 to August 2014



The pattern of our referrals is quite steady throughout the period except for dips in December, April and August.

We are aware that the waiting times for assessment could still be improved and are focussing on that by increasing the number of people offering assessments. We have now included experienced honorary psychologists and psychotherapists as assessors. They offer assessments under supervision and we consider this to be a good use of experienced clinician time. Experienced honorary staff also welcome the opportunity to extend their skills. We are beginning to see some reduction in waiting times for assessment.

Future developments

We are working to improve communication within our diverse workforce (staff including honorary psychologists and psychotherapists) and to identify new ways of working. Recent initiatives include:

a monthly newsletter, bi-monthly clinical meeting, monthly research meeting for staff to read papers and present work in progress, away days and regular early morning coffee.

As outlined, we are working at developing our services both within the IPTT and outside with our colleagues in Assessment and Liaison and Treatment Teams. Within the IPTT and having identified a need to provide a service to the number of young people referred, we are about to trial a young person's Cognitive Analytical Therapy (CAT) service. This consists of young people, where it is considered appropriate by the Single Point of Access meeting (SPA), being referred directly for Cognitive Analytical Therapy (CAT) rather than the waiting list for assessment. They then receive four sessions of CAT, each session standing on its own, and then followed by a session four weeks later. This method of delivering CAT has been trialled elsewhere and is seen to be useful. We are also about to set up a young person's group, which will be a year-long group. Developing the services we offer to young people is important for us and we would like to work with other services, especially colleagues in CAMHS, in developing this work further.

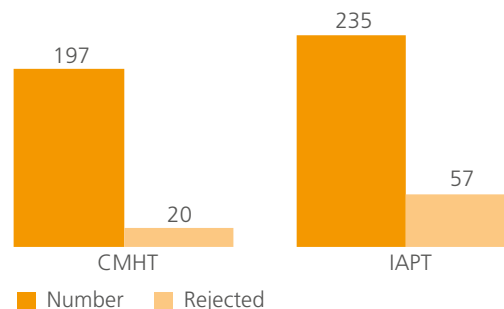
We are also about to begin a joint Lambeth IPTT and Lambeth MAP Treatment Team programme of MBTi which will work with service users who are within the Treatment Team who are identified as having Unstable Personality Disorder (EUPD) and for whom it is thought a psycho-educational programme would be beneficial.

We are currently working on a proposal to provide CAT-informed reflective practice groups for Assessment and Liaison and Treatment Teams.

Lewisham

Lewisham IPTT is a secondary care psychological therapy service seeing patients referred by IAPT and the Lewisham MAP teams and is based at Lewisham Hospital. A range of therapies are provided as well as consultative and indirect work with community Assessment and Treatment Team staff. Service users are given a choice wherever possible, as well as advice as to what type of therapy is indicated.

Figure 15 | Activity numbers from September 2013 to August 2014



An equal number of patients were accepted from IAPT and assessment and liaison per annum (177 each). A higher proportion of assessment and liaison referrals are accepted (90%) than IAPT referrals (24%), as assessment and liaison referrals are first screened by the psychologist working with this team.

Future developments

IAPT liaison

- Setup a link worker to liaise with the four IAPT neighbourhoods in order to offer advice and reduce the number of rejected IAPT referrals.

MAP Treatment Team

- Provide systemic, family and couple therapy to Treatment Team cases and provide consultation to the team.

Assessment and Liaison psychology service

- Reorganise the psychology service to the Assessment and Liaison service by having a single waiting list across the four neighbourhood teams and a link worker system.
- Provide family and couple therapy and consolation to the Assessment and Liaison teams.

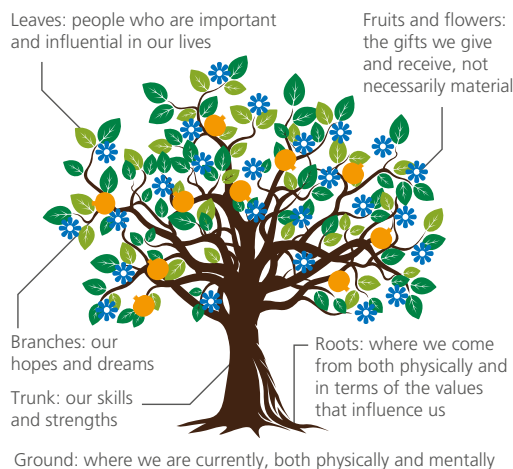
Psychological therapy effectiveness

- Audit which patients do well or less well in which types of and durations of therapy so that we can target therapy at those who can use it. Also address issues of patients who are benefitting from therapy at an earlier stage, either modifying therapy or ending it and referring on, where appropriate.

Peer support

- Develop Tree of Life groups as a new addition to current groups of Mindfulness and the service-user story telling project.

Figure 16 | Tree of Life diagram



- Develop a new garden for staff and service users at St Mary's Church next to Lewisham Hospital. We have been awarded a grant to

develop the garden from the SLaM trustees and will be receiving assistance from the Sydenham Garden Project.

Trauma therapy

- In addition to the two new group programmes, provide yoga and creative writing.
- Evaluate treatment groups.

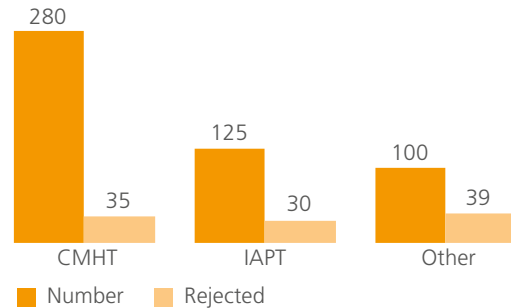
Group therapy

- Increase group therapy provision to reduce waiting times for psychodynamic psychotherapy; provide five psychodynamic psychotherapy groups in addition to the MBT programme.
- The second tranche of the group schema therapy has started, coordinated between Lambeth, Southwark and Lewisham.

Southwark and Central

Southwark and Central IPTT is a secondary care psychological therapy service seeing patients referred by IAPT, Southwark MAP teams and, for particular treatments, IPTTs in Lambeth and Lewisham.

Figure 17 | Activity numbers from September 2013 to August 2014



Looking ahead, we aim to have:

- Engaged, productive staff providing assessment and treatment with excellent outcomes
- Staff, managers, commissioners, referrers, service users and carers viewing the service as excellent
- The full range of patients in the local community with a choice of interventions, collaborating in their treatment and reporting recovery
- Infrequent serious incidents with lessons learned.

Plans to achieve strategic aims

- Review skill mix/reduce waiting times
- Monthly reporting on number of assessment/treatment sessions by modality
- Engage further in reviewing CORE and Work and Social Adjustment Scale (WSAS) data in supervision
- Continue to discuss PEDIC outcomes at Service User Forum
- Audit the demographics of service users and implement recommendations to ensure access to the population we serve
- Enhance understanding of the needs of our patients among those working with them in primary care and CMHTs
- Discuss carers' involvement with Southwark and Central IPTT Senior Management
- Work with Adult Mental Health (AMH) Plan Pathway Leads to look at gaps in service provision and how they might be addressed
- Liaise with Mind and Rethink to enhance links with our service
- Look at the feasibility of developing an IAPT Severe Mental Illness (SMI) service following outcomes from relevant demonstration sites.

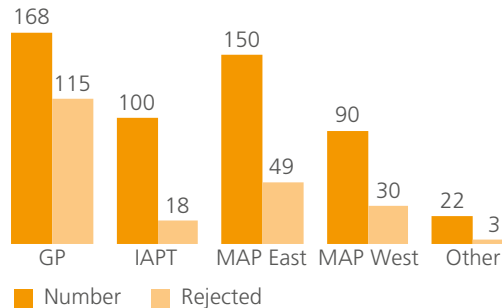
Croydon specific

Croydon Integrated Psychological Therapy Service (CIPTS) is a secondary care psychological therapy service offering consultation, assessment and treatment for service users with moderate to severe complex mental health problems needing an intensive psychotherapy intervention. CIPTS was formed in 2007 when existing services were reconfigured.

CIPTS offers a hub-and-spoke model in terms of consultation, liaison, supervision and teaching to colleagues in the Recurrent Affective Disorders. There are identified CIPTS staff for each team who routinely provide drop-in consultancy slots, team case discussion and attend weekly team meetings.

These roles are provided by both clinical psychologists and psychotherapists, giving the teams access to different models for conceptualising their work. CIPTS has good close-working relationships with both Treatment and Assessment & Liaison teams and occasionally offers clinical supervision around a specific case. CIPTS provides teaching on request and historically has covered topics such as emotion regulation, dissociation, CAT and agoraphobia.

Figure 18 | Activity numbers from September 2013 to August 2014



Going forward, we will:

- Monitor CORE completion rate and outcomes as the accuracy of the data drawn improves
- Efforts to improve PEDIC response rate (e.g. use of new trust devices and new web link for service users)
- Continue to monitor and review assessment and treatment caseloads to ensure efficient service provision
- Work alongside and support the MAP/ Psychological Medicine & Integrated Care senior management team in their efforts to engage the Croydon commissioners in an agreed strategy for addressing CIPTS waiting times (e.g. Supporting CCG-initiated GP review of service users)
- Engage with and contribute to any forthcoming changes in MAP/Psychological Medicine & Integrated Care service

development and delivery in Croydon following plans agreed between SLaM and commissioners (e.g. CIPTS existing and potential role in liaison, consultation and supervision work with MAP colleagues)

- Work with Croydon Head of MAP Pathway, MAP and IAPT team managers to highlight the current under-representation of BME service users referred to CIPTS, as identified in a recent service audit.

Patient experience

Patient experience for the IPTT service

I don't feel totally alone, I have been given a diagnosis and continued support to deal with it and not thrown to the side afterwards.

Ending of treatment should be discussed routinely throughout treatment programmes. Otherwise people can get into a routine of regularly seeing someone and forget that it will come to an end.

Lambeth service

A total of 103 Patient Experience Data Intelligence Centre (PEDIC) responses were returned by service users between August 2013 and July 2014. In order to capture the maximum number of responses, we decided to have three PEDIC months per annum that coincided with our Clinical Outcome in Routine Evaluation (CORE) outcome measure reporting.

What we are doing well	What could be improved
Patients treated with dignity and respect	Developing treatment plans with the patient
Patients saw the professional they expected to see	Options available to patients should be made clearer
Patients' individual needs were taken into consideration	Patients should be more clearly advised about what to do in an emergency mental health situation

PEDIC responses between August 2013 and July 2014:

Lewisham services	Southwark services
Lewisham services respond to feedback through highlighting and addressing concerns through its Service User Forum, improving support through its peer support work and engaging with the wider community on key issues.	Southwark and Central IPTT responds to areas for improvement by reviewing the findings of questionnaires in our Service User Forum, co-facilitated by our Peer Support Development Coordinator and the Head of Service, with a focus group facilitated by a Service User Consultant in the absence of IPTT staff as part of this forum. We use ideas arising from the Forum to generate action plans which are then taken to our Whole Service Meeting for discussion and implementation. Results need to be interpreted with caution due to low numbers.

<p>Positive responses for the following questions</p> <ul style="list-style-type: none"> • Being treated with dignity, empathy and respect • Feeling actively involved in care/treatment • Understanding the purpose of the assessment • Understanding options available following assessment • Individual needs (cultural, spiritual, faith) being taken into consideration 	<p>Positive responses for the following questions</p> <ul style="list-style-type: none"> • Feel actively involved in their care/treatment • Being treated with dignity, empathy and respect • Having their individual needs (cultural, spiritual, faith) taken into consideration • Understanding the purpose of your assessment • Seeing a professional that they knew or expected to see • Trusting the service • Feeling optimistic that this service would help them • The service environment being clean
<p>Areas of improvement</p> <ul style="list-style-type: none"> • Knowing how to make a complaint • Jointly developing treatment plans with a member of staff • Being given a copy of their treatment plan • Several service-users made specific comments. These were mostly positive comments about therapy, the therapist and/or the environment. One person complained about the long wait before she was seen 	<p>Areas of improvement</p> <ul style="list-style-type: none"> • Jointly developing treatment plans with a member of staff • Being given a copy of their treatment plan • Knowing how to make a complaint

For Croydon, the IPTT and Croydon Intensive Psychological Treatment Service (CIPTS) are combined. A total of 24 PEDICs were returned by the service users during this period (range: 0–6 monthly). PEDICs are given to all service users at the end of treatment by either therapists or administrators. Results need to be interpreted with caution due to low numbers. However consistently through the period, PEDIC responses were positive (Yes and Yes to some extent) in areas including:

- Being treated with dignity, empathy and respect
- Feeling actively involved in care/treatment
- Understanding the purpose of the assessment
- Understanding options available to you following assessment

- Your individual needs (cultural, spiritual, faith) taken into consideration.

Areas for improvement included;

- Jointly developing treatment plans with a member of staff
- Being given a copy of their treatment plan
- Knowing how to make a complaint.

In terms of individual service user comments:

- 4 service users complimented their therapists by name
- 4 service users complained about the length of the wait for treatment
- 2 service users complained about the service limits on length of their treatment
- 2 service users complained about the building/facilities at Tamworth Road Resource Centre.

The CAG has taken an overarching approach in addressing service user feedback across these services. Recent initiatives include:

- The introduction of peer support workers. Their role includes assisting with a range of activities and contact for people requiring support whilst waiting for particular clinical treatments and following discharge.
- Through a service user advisory group, the development of factsheets so that people are better informed about services and treatments.
- Targeted work on "getting help in a crisis" including raising awareness of the 24 hour telephone crisis line.
- The development of a Did Not Attend (DNA) and disengagement policy which aims to support people in keeping appointments. The policy take accounts of individual needs in terms of how people would like to be reminded, contacted and supported to attend appointments.

Figure 19 | Number of sessions offered for closed cases across the three boroughs

	IPTT Lambeth	IPTT Lewisham	IPTT Southwark	Total
1–2 events	57	72	48	177
3–5 events	27	33	20	78
6–10 events	21	37	20	78
11–20 events	67	75	29	171
21–30 events	36	36	39	111
31–40 events	22	29	10	61
41–50 events	19	11	8	38
51–60 events	16	3	9	28
60+ events	49	9	13	71
Total	314	305	196	816

CORE outcomes for Lambeth, Lewisham and Southwark from Sept 2013 – Aug 2014

The CORE-OM is the main outcome measure used in SLaM secondary care Psychological Therapies. Service users are asked to respond to 34 questions about how they have been feeling over the past week, with five possible answers ranging from 'Not at all' to 'Most or all of the time'. A shorter CORE-10 which has 10 questions is also available. Answers are then filed in the Electronic Patient Journey System (ePJS).

A CORE analysis was completed for service users who had ended therapy during the period 1st February 2013–end of August 2014.

The table below shows how many of the 658 service users had completed a valid pre-therapy CORE only, and those who had completed both a valid pre and post therapy CORE – referred to as a paired CORE. Valid COREs are those where service users have either completed the questionnaire in full or have only missed a minimal number of items out, as defined by CORE Information Management Systems.

Figure 20 | Sample of services users with and without a pair of CORE measures

	All eligible	Valid pre therapy CORE only	Valid pre and post therapy paired CORE (% of all eligible)
Croydon	32	18	14 (44%)
Lambeth	210	142	68 (32%)
Lewisham	261	127	134 (51%)
Southwark	155	131	24 (16%)
Total	658	418	240 (37%)

Outcome analysis of global distress

A service user's mean global distress (GD) score on the CORE is a rating on a scale of 0–4; a higher score means that the service user is more psychologically distressed. Figure 21 below shows that the mean GD scores were statistically significantly lower post-therapy than pre-therapy with a medium effect.

A 'statistically significant' decrease, as shown here, is one which is highly unlikely to have occurred by chance, allowing one to conclude that the decrease is most probably due to the impact of therapy.

Figure 21 | Pre- and post-therapy global distress CORE scores for each team and overall

	Pre-therapy Global Distress Score	Post-therapy Global Distress Score	Effect Size
Croydon (N=14)	2.32 (SD 0.67)	1.42 (SD 0.90)	1.36 (L)
Lambeth (N=68)	2.12 (SD 0.69)	1.59 (SD 0.71)	0.77 (M)
Lewisham (N=134)	2.12 (SD 0.77)	1.60 (SD 0.77)	0.68 (M)
Southwark (N=24)	2.06 (SD 0.76)	1.36 (SD 0.79)	0.92 (L)
Total (N=240)	2.13 (SD 0.74)	1.56 (SD 0.76)	0.77 (M)

Outcome analysis: clinical and reliable change

There are two ways of assessing whether or not an observed change over time in an individual service user's CORE GD score is significant:

1. **Change in clinical significance:** Service users with pre-therapy scores above the clinical cut-off who subsequently score below it post-therapy are described as demonstrating a positive change in clinical significance, also known as showing recovery.
2. **Reliable change:** Given an observed change in a service user's CORE global distress score, whether or not this change can be considered reliable, is gauged by the extent to which it can be distinguished from changes that may occur by chance or as a direct result

of weaknesses with the CORE. Published research has found that in order for a service user to exhibit reliable change over time, their CORE GD score must change (either increase or decrease) by at least 0.50.

By virtue of service criteria, service users who present to the secondary care psychological therapy teams typically have complex, enduring and treatment-resistant presentations. They may experience a reliable change in GD scores, even though their scores remain clinical post-therapy.

Reliable change, as shown in the table below, shows whether service users who had a pair of COREs and were in the clinical range pre-therapy, had a change in GD score that was statistically reliable regardless of whether their post-therapy score was in the non-clinical or clinical range.

Figure 22 | Change in clinical significance

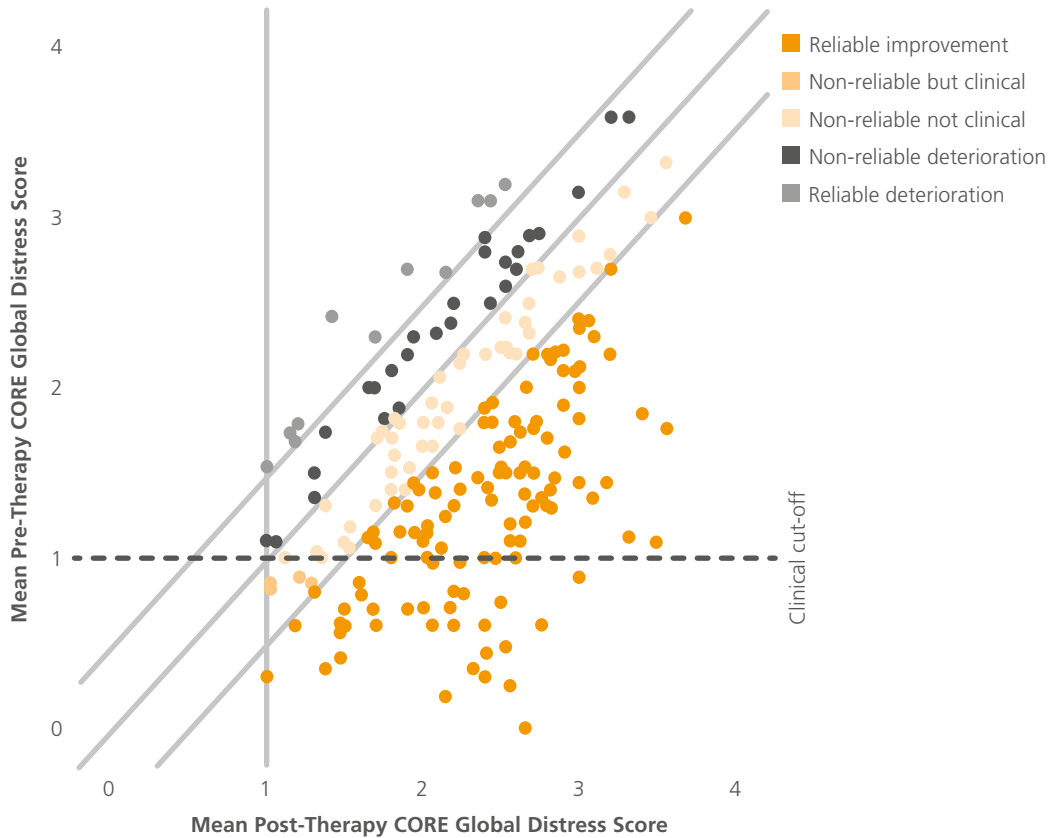
Change	Croydon Number	Lambeth Number	Lewisham Number	Southwark Number	Total Number
Reliable improvement	10 (71%)	35 (56%)	65 (54%)	14 (67%)	124 (56%)
Non-reliable improvement	1 (7%)	18 (29%)	32 (26%)	5 (24%)	56 (25%)
Non-reliable deterioration	3 (21%)	7 (11%)	17 (14%)	1 (5%)	28 (12%)
Reliable deterioration	–	3 (5%)	7 (6%)	1 (5%)	11 (5%)

Figure 23 | Number and percentage of service users who showed clinically significant and reliable change in the GD scores

Change in clinical significance	Reliable change				Total
	Reliable deterioration	Non-reliable deterioration	Non-reliable improvement	Reliable improvement	
'Recovery'	–	–	4 (10.5%)	34 (89.5%)	38 (17.4%)
Remained clinical	11 (6.1%)	28 (15.5%)	52 (28.7%)	90 (49.7%)	181 (82.6%)
Total	11 (5.0%)	29 (12.8%)	56 (25.6%)	124 (56.6%)	219 (100%)

The table shows that 128 of the 219 service users either met recovery or had made a reliable improvement, or both, post-therapy. This equates to 58.4% of the total sample. Eleven individuals or 5.0% of the sample had made a reliable deterioration.

Figure 24 | Reliable/clinical change for those above the clinical cut-off pre-therapy and separated by area



The above graph shows the reliable change and clinical change for service users with pre-therapy scores above the clinical cut-off.

Research and innovation

Centre for Affective Disorders (CfAD)

Professor Allan Young directs the CfAD, which was set up in June 2013. The CfAD is an international centre of excellence for understanding science related to affective or mood disorders and uses this knowledge to help develop new treatments of all types, including psychological and pharmacological. The Centre brings together a number of world-leading clinician scientists at the IoPPN, including co-directors Professors Anthony Cleare and Carmine Pariante. As affective disorders overlap with many other areas of psychiatry and medicine, the Centre is working with a range of colleagues from experimental medicine and other CAGs across King's Health Partners and more widely.

The CfAD's expertise is demonstrated by our researchers' involvement in revising the British Association for Psychopharmacology guidelines, published in May 2015: 'Evidence-based guidelines for treating depressive disorders with antidepressants: a revision of the 2008 British Association for Psychopharmacology guidelines' (Anthony Cleare, Carmine Pariante, Allan Young) and equivalent guidelines for Perinatal (Carmine Pariante and Allan Young) and Bipolar Disorder (Hamish McAllister-Williams and Allan Young).

British Association for Psychopharmacology guidelines

Goodwin, G.M. et al. (2016). Evidence-based guidelines for treating bipolar disorder: Revised third edition recommendations from the British Association for Psychopharmacology. *J Psychopharmacol*, 30(6), 495–553. doi: 10.1177/0269881116636545.

Abstract extract:

The best evidence from randomized controlled trials and, where available, observational studies employing quasi-experimental designs was used to evaluate treatment options. The strength of recommendations has been described using the GRADE approach. The guidelines cover the diagnosis of bipolar disorder, clinical management, and strategies for the use of medicines in short-term treatment of episodes, relapse prevention and stopping treatment. The use of medication is integrated with a coherent approach to psychoeducation and behaviour change.

Cleare, A. et al. (2015). Evidence-based guidelines for treating depressive disorders with antidepressants: A revision of the 2008 British Association for Psychopharmacology guidelines. *J Psychopharmacol*, 29(5), 459–525. doi: 10.1177/0269881115581093.

Abstract extract:

These guidelines cover the nature and detection of depressive disorders, acute treatment with antidepressant drugs, choice of drug versus alternative treatment, practical issues in prescribing and management, next-step treatment, relapse prevention, treatment of relapse and stopping treatment. Significant changes since the last guidelines were published in 2008 include the availability of new antidepressant treatment options, improved evidence supporting certain augmentation strategies (drug and non-drug), management of potential long-term side effects, updated guidance for prescribing in elderly and adolescent populations and updated guidance for optimal prescribing.

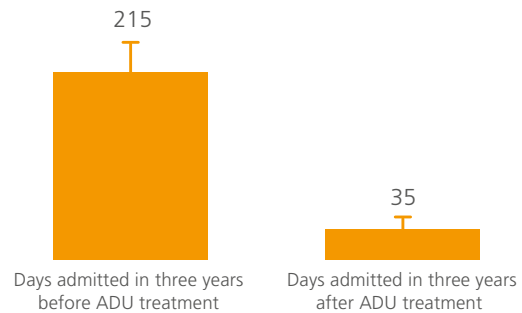
Key personnel

Professor Allan Young holds the Chair of Mood Disorders; his research interests focus on the cause and treatments for severe psychiatric illnesses, particularly mood disorders. The Cognitive Remediation in Bipolar (CRiB) Study is an example of an innovative treatment approach: we are conducting a clinical trial of the feasibility and preliminary efficacy of individual Cognitive Remediation Therapy for people with bipolar disorder recovering from a manic episode.

Professor Anthony Cleare leads the Affective Disorders Research Group focusing on aetiology and improving treatment of severe affective disorders, working within the National Affective Disorders Service. They demonstrated clinical effectiveness of their inpatient programme for

treatment-resistant depression, showing 70% response and reduced bed days post-treatment over three years (2010–2013).

Figure 25 | Affective Disorders Unit: admissions before and after treatment (mirror image study)

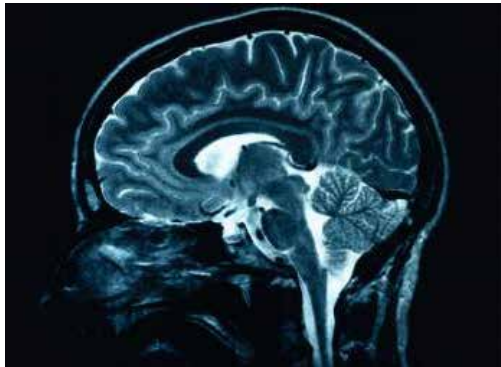


They developed the Maudsley Staging Method for quantifying treatment resistance clinically, and defined novel endocrine biomarkers and clinical factors predicting treatment resistance. They plan to work with service users to research carer burden and adverse physiological effects of caring; to look at the effect of carer stress on patient outcome and develop a carer intervention to reduce stress; to investigate the role of childhood trauma in the aetiology and treatment response of depressive illnesses; and to develop a stratified treatment approach based on identified clinical and biological markers.

Thus, they are developing an integrated, multidisciplinary programme on treatment resistance, combining neuroimaging, neuroendocrine, inflammation, neuropsychological, genetic and clinical predictors and correlates of treatment resistance. They will

focus on biomarkers of treatment resistance and develop capacity in affective disorders neuroimaging training. They plan to research new treatments for the most severe depression including new anti-inflammatory approaches. Addressing the paucity of biological research conducted with neuroimaging techniques that investigate differences between bipolar disorder and unipolar depression, Dr Danilo Arnone researches amygdala neural responses in depression and bipolar disorder.

Figure 26 | Magnetic resonance imaging (MRI) brain scan of a patient with depression



Dr Roland Zahn's research in affective disorders focusses on improving psychopathological assessments, developing neurocognitive predictors of clinical outcomes and on developing novel neurocognitive treatment approaches. His team has recently developed the first robust functional magnetic resonance imaging (fMRI) biomarker of recurrence risk in major depressive disorder.

This neural signature of recurrence risk will serve as the target for a novel randomised controlled fMRI neurofeedback pilot treatment trial which started recruiting at King's College Hospital in 2015. NeuroMooD aims at gathering the clinical proof-of-concept for fMRI neurofeedback in incompletely remitted depression and compares this against a novel way of delivering transcranial direct current stimulation.

This work is based on an earlier collaboration with the D'OR Institute for Research and Education in Rio de Janeiro, the leading Brazilian research institute for translational cognitive neuroscience headed by Dr Jorge Moll to develop a novel software (FRIEND) to deliver fMRI neurofeedback and to show that individuals can quickly learn to modulate neural signatures of complex emotions. Dr Zahn's work on psychopathological assessment of depression has shown that self-blame-related emotions are underestimated in depression, because of an over-focus on guilt, whilst self-disgust is most commonly reported despite not being included in standard assessments. Furthermore, a recent paper has provided the first definitive evidence that vulnerability to major depression is associated with diminished emotions related to blaming others (anger and disgust towards others) which conflicts with the widely-held view that depression vulnerability is associated with a general increase of negative emotions.

Figure 27 | fMRI scanning



These new insights provide the basis for future innovations in improved assessment and better prediction of clinical outcomes. One way of translating this into clinical practice is by gathering a better understanding of patients' needs in primary care and how to improve the primary care/secondary care interface. Dr Hugh Jones has seconded Dr Zahn into a GP practice in Southwark in order to run and evaluate a pilot consultation-liaison service in primary care. This pilot service was originally designed together with Professor André Tylee following a long and successful tradition by Maudsley psychiatrists of seeing patients in GP practices.

Dr Paul Stokes uses neuroimaging to examine the role of the dopamine and GABA neurotransmitter systems in mediating psychosis, addictions and personality traits relevant to psychiatric disorders. His main research interest is to better understand the psychopharmacology and neurochemical basis of bipolar disorder and related co-morbid addictions. Dr Rachel Mitchell is the Programme Lead for the MSc in Affective Disorders. Her research interests concern the cognitive and neural bases of prosodic emotion comprehension, especially in the psychoses,

partnered with a generic interest in impairments of social cognition.

Recent projects include: electrophysiological and behavioural bases of emotional speech processing in subtypes of bipolar disorder; the resolution of ambiguous emotional communication by patients with major depressive disorder and bipolar disorder. Past contributors to the CAG's work on neuroimaging in mood disorders include Cynthia Fu, whose research focuses on neuroimaging-based markers for diagnosis and prognosis in depression.

Dr Alessandro Colasanti's research interest focuses on the biological mechanisms underlying the pathophysiology of affective disorders. Dr Colasanti's translational approach heavily relies on PET imaging, as well as structural and fMRI imaging applications in healthy subjects and patients with neuropsychiatric disorders. Current work includes the characterisation of the role of neuro-inflammatory processes in the pathogenesis of depression in multiple sclerosis using a multimodal imaging approach and the quantification of endogenous opioid release in the living human brain across various patient populations. Future studies will use PET imaging to visualise the effects of stress on the activation of the brain immune system.

Wise, T. et al. (2016). Common and distinct patterns of grey-matter volume alteration in major depression and bipolar disorder: evidence from voxel-based meta-analysis. *Mol Psychiatry* doi: 10.1038/mp.2016.72.

Abstract

Finding robust brain substrates of mood disorders is an important target for research. The degree to which major depression (MDD) and bipolar disorder (BD) are associated with common and/or distinct patterns of volumetric changes is nevertheless unclear. Furthermore, the extant literature is heterogeneous with respect to the nature of these changes. We report a meta-analysis of voxel-based morphometry (VBM) studies in MDD and BD. We identified studies published up to January 2015 that compared grey matter in MDD (50 data sets including 4101 individuals) and BD (36 data sets including 2407 individuals) using whole-brain VBM.

We used statistical maps from the studies included where available and reported peak coordinates otherwise. Group comparisons and conjunction analyses identified regions in which the disorders showed common and distinct patterns of volumetric alteration. Both disorders were associated with lower grey-matter volume relative to healthy individuals in a number of areas.

Conjunction analysis showed smaller volumes in both disorders in clusters in the dorsomedial and ventromedial prefrontal cortex, including the anterior cingulate cortex and bilateral insula. Group comparisons indicated that findings of smaller grey-matter volumes relative to controls in the right dorsolateral prefrontal cortex and left hippocampus, along with cerebellar, temporal and parietal regions were more substantial in major depression. These results suggest that MDD

and BD are characterised by both common and distinct patterns of grey-matter volume changes. This combination of differences and similarities has the potential to inform the development of diagnostic biomarkers for these conditions.

Commercial trials

Professor Allan Young heads the Experimental Medicine and Clinical Trials Cluster of the NIHR Mental Health BRC and attracts funding for the Innovative Clinical Trials Theme which provides infrastructure support for trials in the MAP CAG (approx. £5,262,000 – 2013–2017).

He is the national lead for a commercial trial of intranasal ketamine for patients with treatment-resistant depression, collaborating locally with Dr James Stone. Dr Adam Perkins is investigating the effects of a non-sedating anxiolytic on human brain activity in anxious subjects in the Bionomics trial. In addition, the CAG works with Dr Ayana Gibbs, clinician in the Affective Disorders Service and medical director of Roche Pharmaceuticals, who manages a portfolio of trials for antidepressants.

Key collaborators

Professor Carmine Pariante leads the Centre for the Cellular Basis of Behaviour/Stress, Psychiatry and Immunology Laboratory, focusing on understanding the mechanism operating at the interface between mental and physical health,

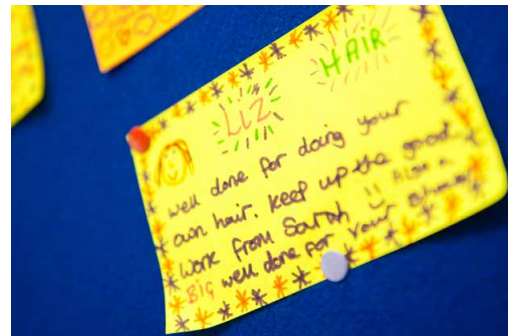
across a variety of clinical and experimental studies. Dr Valeria Mondelli's research focuses on the role of stress – and its biological mediators like hormones and inflammation – in relation to the development of psychiatric disorders, their clinical outcome and the emergence of metabolic abnormalities. Projects in collaboration with the MAP CAG include an investigation of minocycline for treatment-resistant depression.

The CfAD works closely with the Department of Social Genetic & Developmental Psychiatry (SGDP), with which it has historical ties through the research of Professors Anne Farmer (genetic and environmental risk factors for unipolar depression and bipolar disorder) and Peter McGuffin (genetics of normal and abnormal behaviour including psychiatric disorders such as depression, schizophrenia and conduct disorders). In particular, the predictors of outcome following psychological therapy (PROMPT) study works closely with SGDP and contributes samples to the bio-resource.

Public mental health

Dr June Brown's research focuses on public mental health. She has developed a series of one-day psychoeducational workshops for delivery in community settings, which have proved both accessible – attracting difficult to engage groups for example, black and minority ethnic (BME) groups – and effective. Further research is planned to evaluate the accessibility and efficacy of these brief interventions.

Dr Rina Dutta's research interests include suicide, self-harm, causes of premature mortality, mental and physical co-morbidities and the use of datasets for clinical research. She is currently leading a five-year research programme investigating 'Electronic health records to predict Hospitalised Suicide attempts: Targeting Information Technology solutions' (eHOST-IT).



Until I Find You

Until I Find
You



Personality
disorders

Personality disorders

How do we measure clinical outcomes

Clinical Outcomes in Routine Evaluation – OUTCOME MEASURE (CORE-OM) – Global Distress

The CORE-OM is a 34-item generic measure of psychological distress, which is pan-theoretical (i.e. not associated with a school of therapy), pan-diagnostic (i.e. not focused on a single presenting problem) and draws upon the views of what practitioners considered to be the most important generic aspects of psychological wellbeing health to measure.

As quoted in: www.coreims.co.uk/About_Measurement_CORE_Tools.html

The Inventory of Interpersonal Problems (IIP-127 item version) – Distress arising from Interpersonal Sources

The Inventory of Interpersonal Problems (IIP) is a self-report instrument that identifies a person's most salient interpersonal difficulties. Even if a person begins a clinical interview by describing uncomfortable feelings or distressing thoughts, a large number of interpersonal problems usually surface within the first session. Understanding and resolving interpersonal problems is considered an important step for alleviating common symptoms and syndromes, including depression and anxiety.

As quoted in: www.mindgarden.com/113-inventory-of-interpersonal-problems

Work and Social Adjustment Scale (WSAS) – Impaired Functioning

A simple measure of impairment in functioning.

The Cawley Centre – Adult Personality Disorder Service

The Cawley Centre Personality Disorders Service is a specialist service located at the Maudsley Hospital. We provide assessment, care and treatment for people aged over-18 who have severe and complex personality disorders. The service accepts referrals from within SLAM catchment area (predominantly Lambeth and Lewisham). The service also serves as a national service and receives referrals from further afield.

The service runs an intensive day treatment programme that patients attend up to five-days-a-week, for up to two years in duration. The underpinning model is mentalisation based treatment (MBT) which is supported by a Therapeutic Community framework. The treatment programme includes group and individual therapy. Each person is allocated a primary therapist who co-ordinates their care and meets with them at least once a week. Social and occupational functioning is a focus of treatment and there is an occupational therapist in the team. Psychodrama and family therapy are

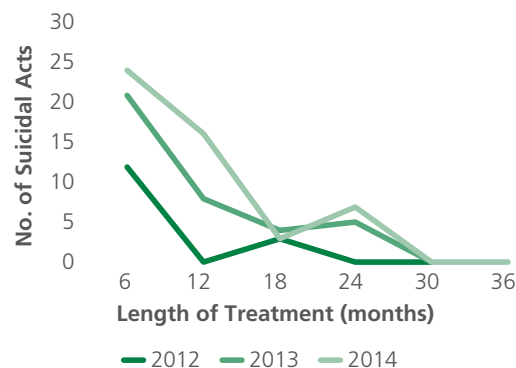
also available. Other activities that take place in the community include cooking groups, art group and gardening.

After assessment, suitable persons can be offered a place in the weekly Starters group immediately, before going on to join the full-day treatment programme. On completion of the two-year programme, patients can join a weekly leavers group for a year.

Outcome measures are used routinely and audits are performed regularly to monitor performance.

Below are graphs depicting the number of suicidal and deliberate self-harm acts attempted by patients at the Cawley Centre whilst in treatment from 2012 to 2014.

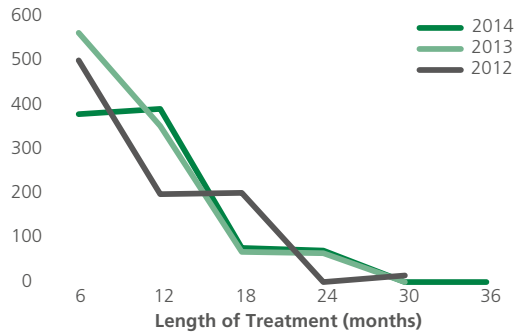
Figure 28 | Number of attempted suicidal acts whilst in treatment (2012–2014)



The graph above shows that even with the steep increase in patients treated in the service year-on-year, the affective treatment has been consistent

in reducing the number of attempted suicides over the course of treatment.

Figure 29 | Number of deliberate self-harm acts whilst in treatment (2012–2014)



The Touchstone Centre – Croydon Personality Disorder Service

The Touchstone Centre provides MBT for individuals who have Emotionally Unstable Personality Disorder (EUPD).

We treat people who have complex interpersonal and behavioural problems which impact negatively on all aspects of their life (i.e. relationships, occupational functioning and education since adolescence).

The person may exhibit:

- Concurrent moderate-to-severe risk of harm to self and others.
- Frequent, often escalating, unscheduled contact across a range of services – chaotically and/or in crisis – including mental health, social services, A&E, GPs, criminal justice system.
- High levels of anxiety elicited in carers, relatives and professionals, who may feel overwhelmed and/or deskilled.
- Poor or unsafe coping skills and a need for external controls/containment in times of stress.
- No stable attachments in the community, other than with services and immediate family (which will be conflictual and highly volatile).

Treatment to date may have involved:

- Many pharmacological and psychological treatments tried previously without success.
- Many experiences of conflictual relationships with health and social care professionals and difficulties engaging and participating in treatment.

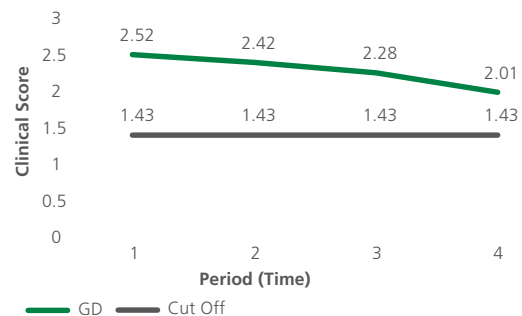
The MBT Programme has places for 16 patients on the two day-per-week Intensive Outpatient Programme (IOP) and 16 Patients on the three day-per-week Day Treatment Service (DTS). Both programmes last for 18 months.

MBT is delivered primarily in groups with individual therapy in place to support engagement within the group setting. Within the context of developing and maintaining attachment relationships with therapists, the treatment aims to strengthen patients' capacity to understand their own and others' mental states in order to address their difficulties with managing feelings, controlling impulsive behaviour and managing/maintaining relationships with people.

MBT delivered by generic mental health professionals in the context of a partial hospital program was cost-effective and superior to treatment-as-usual over a period of 36 months (Bateman and Fonagy 2001,⁴ 2003,⁵ 2009⁶). Treatment effects remained five years after all index treatment had ceased (Bateman and Fonagy 2009).

A study published in 2013 (Jones, Juett & Hill 2013)⁷ demonstrated that patients who completed 18 months of MBT at the Touchstone Centre showed a statistically-significant improvement on the clinician-administered measures relating to psychological, social and occupational functioning, compared to baseline. In addition, the study showed a statistically-significant reduction in bed use at six and 12 months after starting treatment.

Figure 30 | Mean Global Distress (GD) scores for clients in the 2013 cohort



The results indicate significantly high GD scores for clients starting the therapeutic programme,

4 Bateman A, Fonagy P: Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: an 18-month follow-up. *Am J Psychiatry* 2001; 158:36–42.

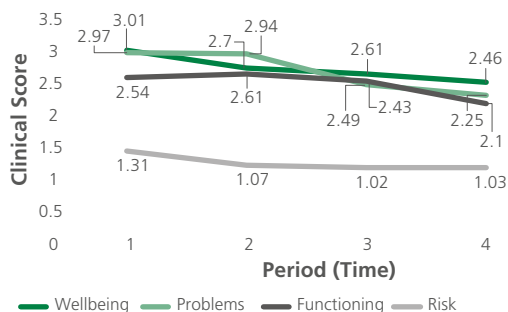
5 Bateman A, Fonagy P: Health service utilization costs for borderline personality disorder patients treated with psychoanalytically oriented partial hospitalization versus general psychiatric care. *Am J Psychiatry* 2003; 160:169–171.

6 Bateman, A, Fonagy, P. (2009) Randomized Controlled Trial of Outpatient Mentalization-Based Treatment Versus Structured Clinical Management for Borderline Personality Disorder. *American Journal of Psychiatry*, 166:1355–1364.

7 Jones, B, Juett, G and Hill, N (2012) A Two Model integrated personality disorder service: effect on bed use. *The Psychiatrist*, 36, 1–5.

which in turn then appear to decrease over the treatment period, up until the end of the course. Nevertheless, mean GD scores remain relatively high and well above the clinical cut off point (1.43).

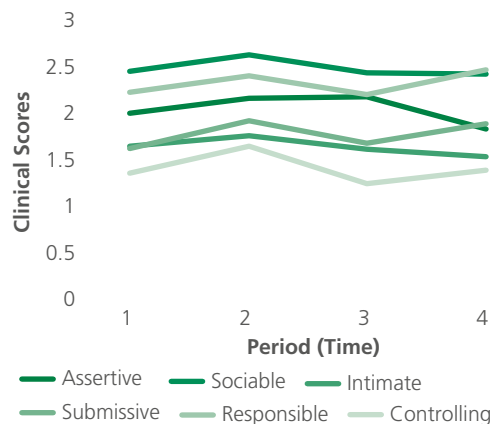
Figure 31 | Compares CORE-OM subscale (Wellbeing, Problems, Functioning and Risk) scores for each time period for the 2013 cohort



The results indicate greater levels of distress for clients in relation to their wellbeing, problems/symptoms and functioning levels. Clinical scores for clients appear to be higher at the onset of the therapeutic programme and gradually decrease towards the end of the programme. Furthermore, clinical scores for 'Problems/Symptoms' remain the highest followed by 'Wellbeing' and 'Functioning'. Surprisingly, clinical scores for 'Problems/Symptoms' appear to show the most change throughout the treatment period compared with any other subscale. Indeed, over time the CORE-OM scores remain high and well above the clinical cut-off scores.

Interestingly, the 'Risk' subscale remains relatively constant (1–1.3) from the onset of the therapeutic programme and sustains this pattern until the end of treatment. Furthermore, 'Risk' mirrors the patterns of its respective subscales and remains well above the clinical cut-off score (0.37).

Figure 32 | Further analysis of the subscales in relation to the IIP mean scores. The results noticeably demonstrate higher distress levels for clients for the subscales 'Sociable', 'Responsible' and 'Assertive'. On the contrary, subscales 'Submissive', 'Intimate' and 'Controlling' appear to cause less distress for clients in inter personal situations



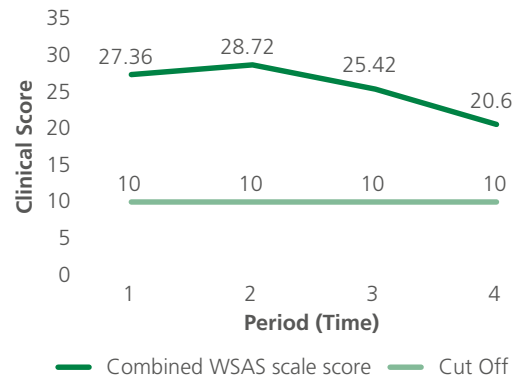
Also, a majority of the above subscales, with the exception of 'Intimate' and 'Assertive', appear to mirror a similar sporadic theme with higher levels of distress with the onset of the programme and again higher levels at the end of treatment.

The 'Assertive' subscale initially begins relatively high but mid-way through treatment appears to decline, possibly implying the positive effects of treatment. The 'Intimate' subscale appears to show lesser levels of distress for clients interpersonally and gradually decreases over the course of treatment. These results could be indicative of clients being able to manage intimate situations more effectively than other interpersonal sources.

Work and Social Adjustment Scale

The Work and Social Adjustment Scale (WSAS) is a measure of general impairment in the following five areas: work, home, social and private leisure and relationships. Impairment in each area is rated on a 0–8 scale. The ratings for each of the five scales are added together to produce a total score with a range from 0–40. Generally, scores of two or less on each scale (or 10 in total) indicate a good outcome/minimal impairment.

Figure 33 | The results evidently reveal that clients in the 2013 cohort are significantly impaired with respect to work, home, social/leisure and relationships (i.e. clinical scores remain well above the recommended score of 10 for minimal impairment). Nonetheless, it is apparent from the results that clients have higher impairment upon starting the programme, which in turn gradually decreases over the treatment period



Other clinical outcomes

The following shows the clinical outcomes for patient who completed either the two days-per-week or three days-per-week MBT.

Functioning type	Median (IQR)/Mean (SD)	Baseline	After 18 months	Standardised 2-tailed	
				Test statistic	sig*
GAF ratings	Median	31 (16)	50 (7)	Z = 2.371	p = 0.018
Social Adjustment score	Median	3.20 (0)	3.35 (1)	z = 0.674	p = 0.500
Interpersonal functioning	Mean	2.11 (0.51)	2.25 (1.01)	z = 2.11	p = 0.735
CORE-OM Global distress	Mean	2.35 (1.77)	2.71 (0.65)	z = 0.847	p = 0.397
Symptom distress					
BSI Total Distress	Mean	58.00 (7.81)	42.60 (2.30)	T = 4.363	p = 0.012*
BSI Somatisation	Mean	16.20 (4.32)	10.20 (2.86)	T = 2.711	p = 0.054
BSI Depression	Mean	21.60 (2.07)	15.00 (2.45)	T = 4.598	p = 0.010*
BSI Anxiety	Mean	20.20 (2.86)	17.40 (2.40)	T = 2.622	p = 0.059
Beck Depression Inventory	Mean	43.29 (11.98)	42.57 (15.50)	T = 0.238	p = 0.820
PHQ depression	Mean	19.43 (8.96)	18.29 (7.63)	T = 0.298	p = 0.776
Spielberger Anxiety (trait)	Median	74.00 (18)	69.50 (13)	Z = -0.677	p = 0.498
Spielberger Anxiety (state)	Median	70.83 (10.53)	62.83 (9.52)	T = 1.581	p = 0.175
GAD-7 anxiety		18.00 (14.00)		Z = -0.530	p = 0.596
Quality of Life					
HoNOS	Median	17.75 (6.5)	9.50 (5.7)	Z = -2.197	p = 0.028*
EQ-D5 VAS	Mean	37.86 (29.98)	44.29 (23.17)	T = 0.380	p = 0.717

* = significant at <0.05

The Service User Network (SUN) Project – A crisis support and coping skills group

The SUN Project is a community-based open access service for people with personality disorder. It provides a service to help people with personality disorder. The service aims to help patients to cope better, manage crises more effectively to prevent emergencies and to empower them to manage their difficulties by gaining more control over their thoughts, feelings and behaviours. It aims to help people with severe difficulties who may be: unable to engage regularly with other services; high risk and high users of emergency services and high co-morbidity, including addiction problems.

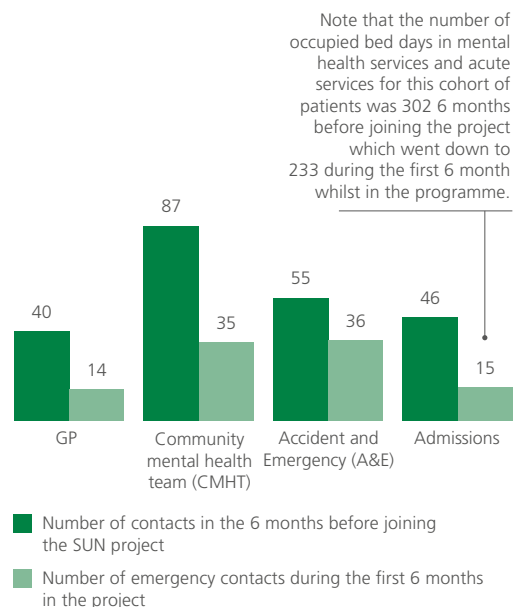
To do this, the SUN Project utilises a clinical model based on coping process theory, which is a type of talking therapy delivered in groups. Specifically, thoughts, feelings and behaviours are modified to achieve improved coping with difficulties.

This project offers a service for people who would not otherwise access services, as many barriers to access have been removed so far as it is safe to do so. The project accepts self-referral only. Once an individual has contacted the service, after being given information, they are asked to attend the next available group (usually within one to two weeks) to meet other group members. They can join the SUN Project after completing a Crisis and Support Plan (CASP) which is the first step in the clinical model to improve coping. Individuals are

not formally assessed in the conventional sense, but rather are assessed within the group by the group. This is an important aspect of the model (i.e. to promote a sense of difficulties & risks being identified, contained and altered by the group itself).

The SUN Project supports people, improves their coping and sense of wellbeing and reduces risk, as evidenced by decreased attendance at Accident and Emergency departments and reduces need for other service use (Miller and Crawford 2010, Gillard et al 2012, and Jones et al 2012).

Figure 34 | Graph showing the reduction in emergency contacts before and during the six months of treatment



References

Jones B, Juett G, Hill N (2012). A two-model integrated personality disorder service: effect on bed use. *The Psychiatrist*, 36(8), August 2012, pp.293–298.

Gillard S, Adams K, Edwards C, Lucock M, Miller S, Simons L, Turner K, White R, White S and The Self Care in Mental Health research team. (2012) Informing the development of services supporting self-care for severe, long term mental health conditions: a mixed method study of community based mental health initiatives in England. *BMC Health Services Research* 2012, 12:189.

Miller, S. and Crawford, M.J. (2010): Open access community support groups for people with personality disorder: attendance and impact on use of other services. *The Psychiatrist*; 34: 177–181.

Quality of care outcomes for the service

Figure 35 | Snapshot of the results from a dashboard produced for a Department of Health project

Project		SW London
Cost effectiveness	Inpatient bed use	↓
	Emergency service utilisation	↓
	General Practitioner (GP) use	-
	Out of areas costs	-
	Total number of health and social care appointments	-
Clinical effectiveness	No longer meet criteria of PD Diagnosis	-
	Crises and emergencies	↓
	Coping Skills	↑
	Partnership working	↑
	Ease of access to service	↑
	Quality of Life	-
	Social functioning	↑
	Employment, training and education	-
	Engagement	↑
	Organisational skills	-
	Meaningful activity increased	-
CORE outcomes	-	
Patient and carer satisfaction	Service user satisfaction	✓
	Service users views	+
	Carers Support	✓
	Complaints	↓
Patient safety	Emergencies	↓
	Inpatient bed use	↓
	Self-harm incidents	↓
	Suicide acts	↓

Intensive Psychological Treatment Service (IPTS)

This service evaluation uses information from clients of the Intensive Psychological Treatment Service (IPTS). These clients are of the 2013 cohort (i.e. they were in the intensive three day-a-week programme or the one day-a-week transition and support programme at some point between 1st of April 2013 and March the 31st 2014). Data for this report was taken from ePJS and the IPTS clinical measures database up to the 1st September 2014 and is currently being analysed. The results will be available in the next edition of the outcome booklet.

This report will evaluate gender and age patterns, ethnicities, referral patterns, clusters, diagnoses and past historical factors with relation to their diagnoses. Furthermore, clinical measures will be analysed to provide a greater insight into the symptomology of the clients whilst attending the programmes.

The IPTS's 2013 Cohort consisted of 35 clients who were in the intensive three day-a-week programme or the one day-a-week transition and support programme at some point during 2013/2014. A total of 17 new clients joined the three day-a-week programme/one day-a-week programme in this current cohort.

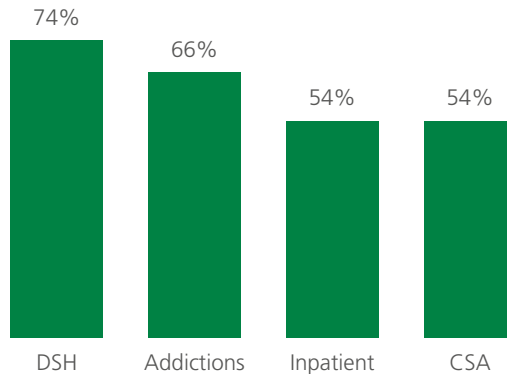
Figure 36 | Diagnosis for clients on the programme

Diagnosis	Code	No.
Emotionally Unstable Personality Disorder	F60.3	24
Bipolar Affective Disorder	F31	4
Personality Disorder Unspecified	F60.9	1
Recurrent Depressive Episode	F33.9	1
Post-Traumatic Stress Disorder	F43.1	1
Mixed and Other Personality Disorder	F61	1
Mixed Anxiety and Depressive Disorder	F41.2	1
Mental and Behavioural Disorder due to Cannabinoids	F12	1
Mental Disorder due to Alcohol Use	F10.1	1
Other Phobic Anxiety	F40.8	1
Mental Disorder	F99	1

Client History

The client history of participants in the 2013 cohort was taken in the form of inpatient admissions, exposure to addictions, deliberate self-harm (DSH) and child sexual abuse (CSA). The below figure demonstrates DSH as the most common.

Figure 37 | Client history on programme



About the client group

1. 83% of the patients were female
2. The modal type of client for the IPTS is a female between the ages of 41 and 51. There also appears to be a greater number of female clients aged between 31 and 40 years old
3. There were no males in the 2013 cohort aged between 18 and 30 years
4. The average age for a client at the IPTS was 41 years old
5. The modal ethnicity for the 2013 cohort was British and the second was English*
6. A higher number of referrals that were accepted for the treatment programme came from Southwark North and Southwark South than any other referrer. The Northover and Speedwell services and the Ladywell Unit also refer a significant number of appropriate clients to the IPTS (4, 3 and 3 respectively). The remaining referrers appear to have similar number of successful referrals.

*Note: British most often refers to white British people and ethnicities are self-reported, thus clients who could be classified as British may classify themselves as "Any other Group" or "Other white unspecified", or subsequently classify themselves British when they are of another ethnicity.

Conclusion

The report concluded that the majority of patients at the IPTS had a diagnosis of Emotionally Unstable Personality Disorder, were predominantly self-harmers and had high levels of addictions. The report also highlighted that a significant number of patients had a previous history of inpatient experience, as well as childhood sexual abuse. The modal patient was a British female in her forties.

The clinical measures applied to the clients reaffirmed high levels of psychological distress, depression and anxiety. The results also indicated high levels of impaired mental functioning, specifically with regards to interpersonal functions.

Research and Innovation in this care pathway

Dr Paul Moran was the academic lead for personality disorders from 2010–2015. His research focuses on the clinical epidemiology and management of personality disorder (PD) and related behavioural disturbance, including self-harming. A key achievement of Dr Moran's

work whilst working with the MAP CAG was the first description of the psychosocial and clinical outcomes of adolescents who self-harm (with colleagues at University of Melbourne). This study was published in the Lancet and was featured in international news outlets, including the Today programme (Radio 4), Sky News and Times of India.

During his time with the MAP CAG and working with colleagues at IoPPN, Dr Moran also conducted the following other key pieces of research: the development of the Standardised Assessment of Personality Abbreviated Scale (SAPAS) for PD screening (which has now been widely adopted and is used to routinely screen large numbers of people referred to IAPT services); a study of the violent victimisation of people with mental disorder in SLAM; a randomised controlled trial (RCT) of joint crisis planning for people with Borderline Personality Disorder; examination of life expectancy and cause-specific mortality of people with PD*; and a comparative study of service utilisation patterns adopted by people with PD and severe mental illness* (*work led by Dr Moran's MD(Res) student, Dr Marcella Fok). Dr Paul Moran is now a Reader in Psychiatry and Honorary Consultant Psychiatrist based at University of Bristol, and continues to collaborate with MAP CAG.

Current projects involving MAP researchers include:

- the development and testing of a web-based Decision Aid for Young people who Self-harm (DASH, led by Dr Paul Moran)
- investigating the extent of use, clinical rationale and effect of prescribing psychotropic medication for patients with Personality Disorder (led by Dr Steve Miller and funded by the BRC)
- a multi-national RCT of group schema therapy (GST) comparing GST with treatment as usual in patients with borderline personality disorder (ESTEAM, led by Arntz et al, University of Amsterdam and at the IoPPN/SLaM by Dr Anna Lavender with Dr Helen Startup and Dr Florian Ruths)
- investigating the correlates of personality difficulties in the community population of south east London (SELCOH) (led by Dr Marcella Fok)
- validating a Chinese version of the SAPAS among Hong Kong psychiatric patients (led by Dr CM Leung, Shatin Hospital, Hong Kong, in collaboration with Dr Marcella Fok)
- investigating the feasibility and acceptability of Cognitive Remediation Therapy as a psychological treatment for borderline personality disorder (BPD) (led by Dr Clare Reeder)
- feasibility study of a psychoeducational parenting intervention for families with parental personality disorders and child mental health needs (led by Dr Crispin Day, CAMHS CAG)

Moran, P et al. (2012) The natural history of self-harm from adolescence to young adulthood: a population-based cohort study. *Lancet*, 379(9812):236–43. Open Access: www.sciencedirect.com/science/article/pii/S0140673611611410

Summary

Background. Knowledge about the natural history of self-harm is scarce, especially during the transition from adolescence to young adulthood, a period characterised by a sharp rise in self-inflicted deaths. From a repeated measures cohort of a representative sample, we describe the course of self-harm from middle adolescence to young adulthood.

Methods. A stratified, random sample of 1943 adolescents was recruited from 44 schools across the state of Victoria, Australia, between August, 1992, and January, 2008. We obtained data pertaining to self-harm from questionnaires and telephone interviews at seven waves of follow-up, commencing at mean age 15.9 years (SD 0.49) and ending at mean age 29.0 years (SD 0.59). Summary adolescent measures (waves three to six) were obtained for cannabis use, cigarette smoking, high-risk alcohol use, depression and anxiety, antisocial behaviour and parental separation or divorce.

Findings. 1802 participants responded in the adolescent phase, with 149 (8%) reporting self-harm. More girls (95/947 [10%]) than boys (54/855 [6%]) reported self-harm (risk ratio 1.6, 95% CI 1.2–2.2). We recorded a substantial reduction in the frequency of self-harm during late adolescence. 122 of 1652 (7%) participants who reported self-harm during adolescence reported no further self-harm in young adulthood, with a stronger continuity in girls (13/888) than boys (1/764). During adolescence, incident self-harm was independently associated with symptoms of depression and anxiety (HR 3.7, 95% CI 2.4–5.9), antisocial behaviour (1.9, 1.1–3.4), high-risk alcohol use (2.1, 1.2–3.7), cannabis use (2.4, 1.4–4.4), and cigarette smoking (1.8, 1.0–3.1). Adolescent symptoms of depression and anxiety were clearly associated with incident self-harm in young adulthood (5.9, 2.2–16).

Interpretation. Most self-harming behaviour in adolescents resolves spontaneously. The early detection and treatment of common mental disorders during adolescence might constitute an important and hitherto unrecognised component of suicide prevention in young adults.



Engagement,
Assessment
and
Stabilisation

Engagement, Assessment and Stabilisation

Engagement Assessment and Stabilisation

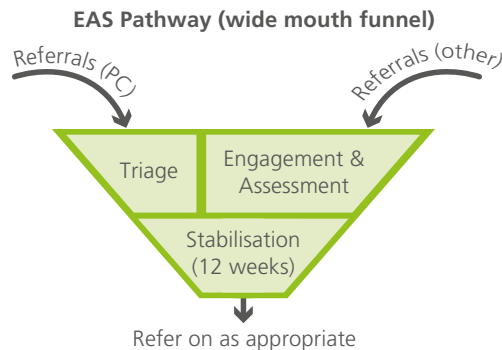
Engagement, Assessment and Stabilisation (EAS) Care Pathway

The Engagement, Assessment and Stabilisation (EAS) Care Pathway is an ambitious care pathway that underpins the delivery of safe and effective treatment and care by our front line Assessment & Liaison teams, based in each of four boroughs (Lambeth, Lewisham, Croydon and Southwark); the teams being aligned to GP/primary care boundaries.

The EAS care pathway (via the Assessment & Liaison teams) is the key gateway into secondary care, facilitating access to mental health expertise up to secondary and tertiary tiers of mental health care and some aspects of Social Care.

The Assessment & Liaison teams provide enhanced services in the form of highly-capable community teams and in some areas providing services until 7pm during weekdays. The EAS care pathway provides a front-end function/service that can support external referrers to better navigate secondary care. This 'wide funnel' front end (Figure 38) allows for more consistent service delivery that is borough-based and retains local connections that are still required for an effective, multi-agency approach to delivery of mental health care at this community/secondary care interface.

Figure 38 | MAP Assessment and Liaison accepted referrals



Refer back to primary care

or

Refer on to more intensive service such as IPPT

or

Refer on to Crisis service such as Home treatment team

The strategy to support implementation of this pathway has enabled staff to deliver responsive engagement, person-centred assessment and effective stabilisation within a 12-week timeframe for at least 80% of the service users seen.

The EAS care pathway supports referrals from a wide range of sources, but mainly from primary care and is designed for individuals who are:

- aged between 18–65 years, with mental health problems, and

- who meet NICE Guidance stepped care criteria for referral to secondary mental health care. For non-urgent referrals, this ensures that interventions have been tried within primary care before referring on to secondary mental health services.

High demand on secondary services make it imperative that there is effective gatekeeping and a high level of competency in assessments. Each Assessment & Liaison team is able to provide expert advice and consultation to help primary care, adult social care and other agencies support individuals with mental disorder, so reducing the need for ongoing secondary mental health care. The Assessment & Liaison services delivered at the interface with the community and secondary mental health services are crucial to sustainability for managing demand for mental health care within the SLAM catchment area.

Key principles that have underpinned development of the EAS care pathway are:

- promotion of single point of access for referrals
- prompt response to referrals
- timely throughput of patients from front-end services within 12 weeks, thus ensuring sustainability and responsiveness to demand
- reducing the separation of mental health and physical health care, and

- ensuring educational, training and supervision needs of staff are met.

Appointment of an Education and Training Lead has played an important part in developing and maintaining a high level of quality standardised assessment and formulation skills and team processes to enable improvements and effective working within the MAP CAG Assessment & Liaison teams.

The forging of good working relationships with key stakeholders (primary care, patients, carers, social services, 3rd sector and other secondary mental health services) and measurement and feedback to stakeholders of our work across the EAS care pathway forms an essential component of the EAS strategy to deliver quality outcomes and continuous service improvement.

Definition of EAS

Our local services in Croydon, Lambeth, Southwark and Lewisham include Assessment and Liaison Teams which provide initial assessment and 12-week stabilisation to people referred by their local GPs, as well as treatment services delivered in outpatient or community mental health team settings. Accepted referrals and average caseload sizes are often determined by the locally agreed service model. For example, the Living Well Network Hub in Lambeth, offering a front door to mental health and referral on into secondary care assessment services in the borough. Caseload sizes again reflect differing service models with lower numbers reflecting follow through in other services that provide targeted interventions for specific needs and or differing primary care based working relationships.

Figure 39 | MAP Assessment and Liaison accepted referrals

Engagement

The approach taken with service users is drawn from the SLaM Five Commitments:

- 1) Be kind, caring and polite;
- 2) Be prompt and value your time;
- 3) Take time to listen to you;
- 4) Be honest and direct with you;
- 5) Do what I say I am going to do.

The creation of a culture of positively engaging with service users and their carers and supporting a collaborative, empowering approach where service users and carers are active participants in their care.

Assessment

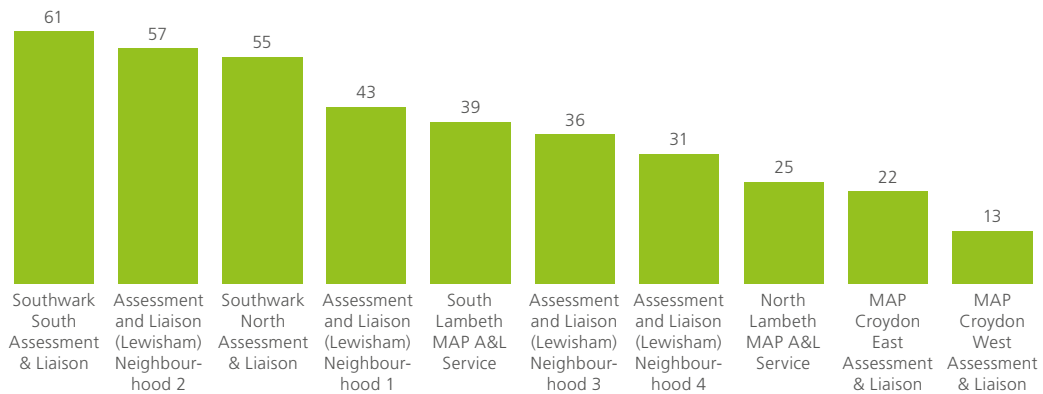
A comprehensive evaluation of a patient's mental health needs using a biopsychosocial framework is made – including physical health, social needs, vulnerability and other risks that impact on ability to function; carers and significant others recognised as part of that assessment process; and in so doing ensure:

- that the care and treatment provided addresses the needs that matter the most to patients and carers, and supports recovery;
- that accurate information is obtained to inform decision making about care and treatment;
- that risk to self and others is identified and managed safely and effectively.

Stabilisation

Stabilisation involves early treatment, interventions and/or support that reduces or alleviates the presenting problems faced by the patient that contribute to the individual's mental state and impair their ability to function and, in some cases, renders them vulnerable and can compromise their own safety and the safety of others.

Figure 40 | Average caseload for each of the treatment teams



What has been achieved to date in the development of the EAS care pathway?

- Borough-based, local implementation workshops were held with front-line staff in MAP CAG Assessment & Liaison community teams throughout 2015 with the following agenda:
 - Communicate what the EAS care pathway will mean for their Assessment & Liaison team practice
 - Think, learn and test the implementation of the EAS pathway in day-to-day practice

- Identify solutions to any road blocks to implementation
- Agree a team specific action plan for future implementation
- Developed three simulation training programmes to improve community psychiatry assessment skills (ComPASS) which are held at the Centre for Mental Health Simulation (SLaM).

Family interventions

We have introduced family interventions into the MAP treatment services for example in Lambeth where additional training and dedicated resource has led to an increase in the amount of family focussed work and family interventions offered as part of the stabilisation service.

Assessment and Liaison Service

The Assessment and Liaison Service operates across the Lambeth, Lewisham, Croydon and Southwark boroughs and is for residents with mental health problems. The service works to each of the boroughs' GP neighbourhoods and assesses people who are referred according to the following timescales:

- within 24 hours – for urgent referrals
- within 7 days – for priority referrals
- within 28 days – for routine referrals.

The Service provides expert advice and consultation to help primary and adult social care colleagues look after patients, where possible, without the need for a secondary mental health service.

Autism and Attention Deficit Hyperactivity Disorder (ADHD) Service

Located in Lewisham Hospital, the service provides diagnostic assessments of adults with Autism Spectrum Disorder (ASD) and/or Attention Deficit Hyperactivity Disorder (ADHD/ADD) and initial medical management of ADHD symptoms.

We also have a specialist ASD/ADHD psychology service that provides psychological treatment

for adults with ADHD and adults with ASD who have additional mental health problems/behaviour problems.

Mental Health Awareness for Administrators

- Rolling training programme developed at team level following training needs assessment
- In partnership with SLaM Recovery College, workshops on understanding MAP CAG Assessment & Liaison community team assessments.

Other services

H2: Reablement Service based in Southwark

The Reablement Service – Southwark offers a skills development programme to support adult residents of Southwark who are attending the adult community mental health teams and the Maudsley Inpatient Units, where health may restrict or inhibit daily living.

The service offers skills development in the following Adult Social Care domains: Meal Preparation, Personal Hygiene, Managing Toileting Needs, Being Appropriately Clothed, Being Able

to Make Use of your Home Safely, Maintaining a Habitable Home (including housework, laundry, shopping, correspondence and administering finances), Developing or Maintaining Family or Other Personal Relationships, Accessing and Engaging in Work, Training or Volunteering, Making Use of Necessary Facilities in the Local Community, including Public Transport and Recreational Facilities or Services and Carrying Out any Caring Responsibilities for a Child/ Other Dependent.

The Lambeth Living Well Network

The Lambeth Living Well Network Hub is the front door to community-based support for people's mental health and wellbeing in the borough of Lambeth. We work alongside GPs to ensure that people can gain access to personalised support that enables them to:

- Stay well and experience sustainable recovery
- Have choice and control in all their decisions
- Participate in the community on an equal footing alongside their neighbours

Clinical outcomes

The CAG are developing fidelity measures for the EAS care pathway in order that progress and success of the pathway can be monitored and measured. These will be included in a subsequent edition of the outcomes book.

EAS is a newly-formed care pathway and is pivotal to the delivery of sustainable and effective mental health care. Key work has commenced to develop appropriate outcome measures and research programmes that can support further EAS pathway development.

The pathway cuts across different secondary and tertiary care services and defines the primary/secondary care interface. It thus plays a crucial role in tackling one of the biggest challenges: widening access to mental health care whilst improving its quality.

Research innovation in this care pathway

The EAS care pathway is in its infancy and as such we are only now beginning to articulate, develop and agree relevant research questions and outcome measures to know how effectively care can be delivered in this pathway. Some work areas being considered are listed below:

- Supporting MAP clinicians in developing practically relevant research questions
- Supporting MAP academics to collaborate with clinicians in clinical academic teams
- Engagement with services – DNA rates and how these can be influenced
- Why patients (known and unknown) use local A&E services and how this could influence further development of EAS care pathway with Home Treatment Teams/Psychiatric Liaison Nurse interfaces
- Decision-making in Assessment & Liaison teams – how decision support systems can make use of clinical information and computerised tests to improve triage and treatment decisions within Assessment & Liaison teams
- Patient symptom and satisfaction outcome measures
- Stakeholder feedback e.g. from Primary Care.

Education and training

MAP CAG staff contribute to and benefit from a range of professional training. There have been many developments over the last year.

- The Improving Access to Psychological Therapies (IAPT) services received a tailored programme of workshops delivered by the Centre for Anxiety Disorders and Trauma (CADAT), as well as attending the annual British Association of Behavioural Cognitive Psychotherapy (BABCP) conference, where they have delivered a number of the workshops. They also had their annual intake of IAPT trainees.
- CADAT and the Affective Disorders Residential Unit (ADRU) provide a significant input into the High Intensity IAPT training course run by the IoPPN.
- A particular emphasis has been placed on education and training for the community mental health teams, both the Assessment and Liaison teams and the treatment teams. For example, CBT training is now provided to the Recurrent Affective Disorders by CADAT staff and others.
- The CAG now has an Education and Training Lead for the Engagement, Assessment and Stabilisation (EAS) pathway. A training needs analysis of the community teams was conducted and bespoke training developed, in addition to on-site one-to-one training and coaching to team leaders, clinical and non-clinical staff.
- The CAG has embraced the opportunity to develop simulation training days with the help of Maudsley Simulation (the UK's first simulation training centre focusing on mental health). These have included training in assessment and formulation and working with families and networks. Other simulation days going forward will include customer service and working with challenging people.
- Other training events that have taken place include workshops delivered by Affective Disorders Intensive Treatment Service (OPTIMA) on bipolar disorder and depression, as well as workshops on dialectical behaviour therapy, which were both very well received by staff.
- SLAM Partners have a large presence in the MAP CAG this year, with the introduction of

the AMH model in Lambeth and Lewisham and the reorganisation of Assessment and Liaison services in Southwark. They have provided joint coaching and leadership training to the team leaders and consultant psychiatrists.

- The Service User Advisory Board also participated in a number of events including selection and recruitment training.
- The MAP CAG provided a number of external training courses to GPs in Lewisham and in Southwark and has developed a significant number of co-produced training events for the SLAM Recovery College (such as 'Introductory Training on Psychological Therapies' and a module on bipolar disorder with a co-leader with lived experience). CADAT have co-developed five workshops so far with the Recovery College, which nominated CADAT for the SLAM Psychology and Psychotherapy Service User Involvement Group award in December 2015.
- MAP CAG academics and clinicians teach on a range of postgraduate programmes across several IoPPN departments. For example, most clinicians in CADAT are involved in the delivery of the PgDip and PgCert in Cognitive Behaviour Therapy at the IoPPN, while all the tertiary Affective Disorders Service clinicians contribute to the MSc in Psychiatric Research, the MSc in Clinical Trials, the MSc in Neuroimaging and the MSc in Clinical Psychology at the IoPPN.
- In 2015, we launched the first MSc in Affective Disorders programme, which combines world-class specialised graduate training in affective disorders with a strong clinical component. The number of Affective Disorders students for 2015/16 is 22. A multidisciplinary approach is used, drawing on the latest research from a range of disciplines including:
 - psychiatry
 - psychology
 - genetics
 - neuroscience
 - psychopharmacology
 - epidemiology
 - biostatistics

Learning Hub

Introduction to Anxiety

The Kings Health Partners Learning Hub is an education and training resource developed for staff, student and trainees at King's Health Partners. Consultants at King's Health Partners created a resource to help all health care staff recognise when anxiety may be a problem in a person's life, additional modules were created to help clinicians assess, diagnose and treat a wide spectrum of anxiety disorders, particularly those working in the community and IAPT services.

Staff satisfaction

Effects on patient care

Studies have shown satisfaction levels among hospital staff are closely linked to the quality of healthcare they provide. Previous research has tended to focus on single aspects of staff experience or one staff group. Few studies have directly examined the relationship between staff experiences of work and patient experiences of care at the team or individual level.

A study led by the National Nursing Research Unit at King's College London in 2012 identified variation in patient experience within Trusts and suggests this is significantly influenced by staff wellbeing at work and work experiences. The report concluded that in environments where staff reported high demands on their time; little control over how best to meet those demands; where there was a culture of harassment and bullying; where there was little investment in the local team; and a situation where unsupported leaders tried to implement change but then left after a short time, leaving staff with a constant stream of new managers or none at all, staff were not enabled to provide high-quality care for a range of patient groups.

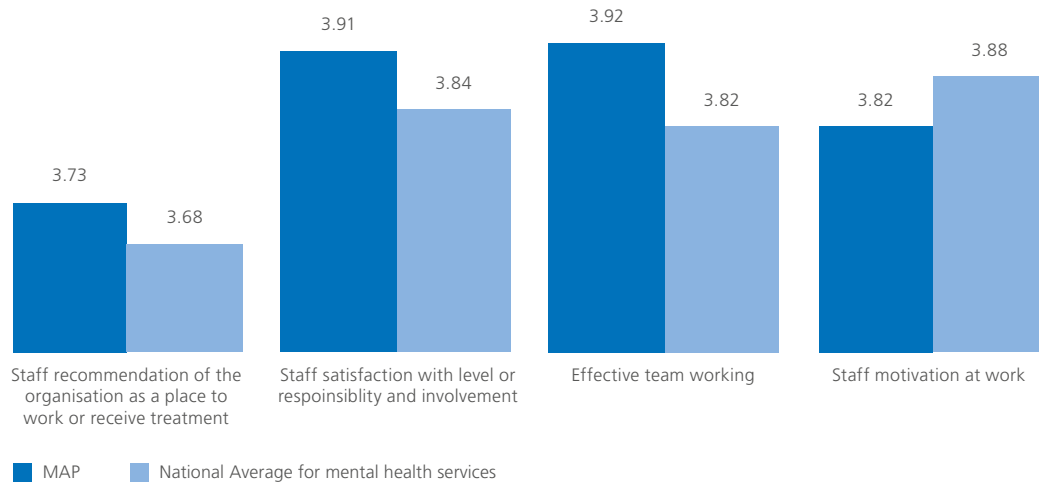
Associations between various aspects of staff wellbeing and patient experience have been reported, mostly at whole-hospital or systems level. For example, the national staff and patient surveys have been compared and the national staff survey has been compared with various patient outcomes.

Research suggests situating staff experience (as well as patient experience) centre stage maybe one of the best actions senior leaders can take.

Analysis of the staff and patient experience surveys indicate seven staff variables that are linked to good staff-reported experience. These are:

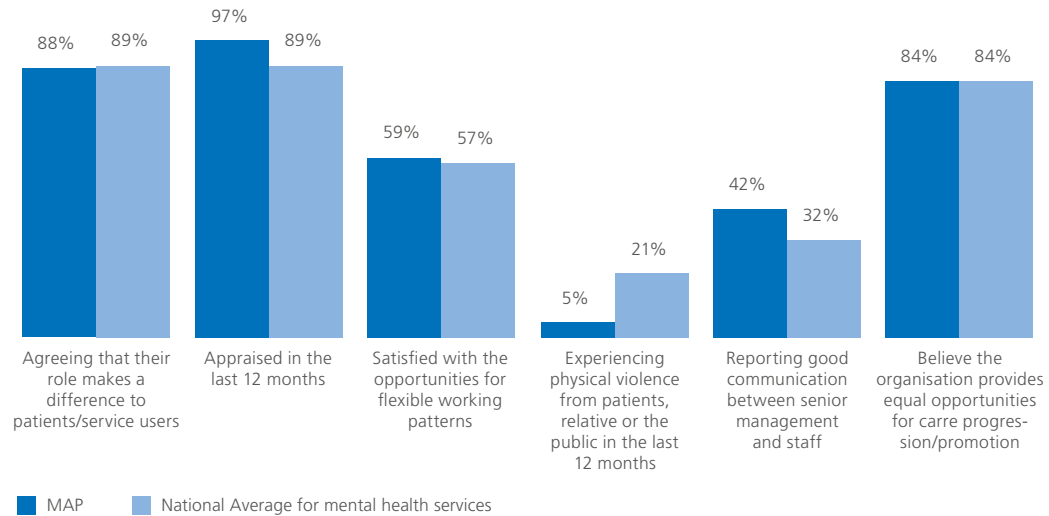
- a good local team/work group climate
- high levels of co-worker support
- good job satisfaction
- a good organisational climate
- perceived organisational support
- low emotional exhaustion and
- supervisor support.

Figure 41 | MAP CAG scores from a selection of questions from the 2015 national staff survey (scores 1 to 5)



Note: Questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5.

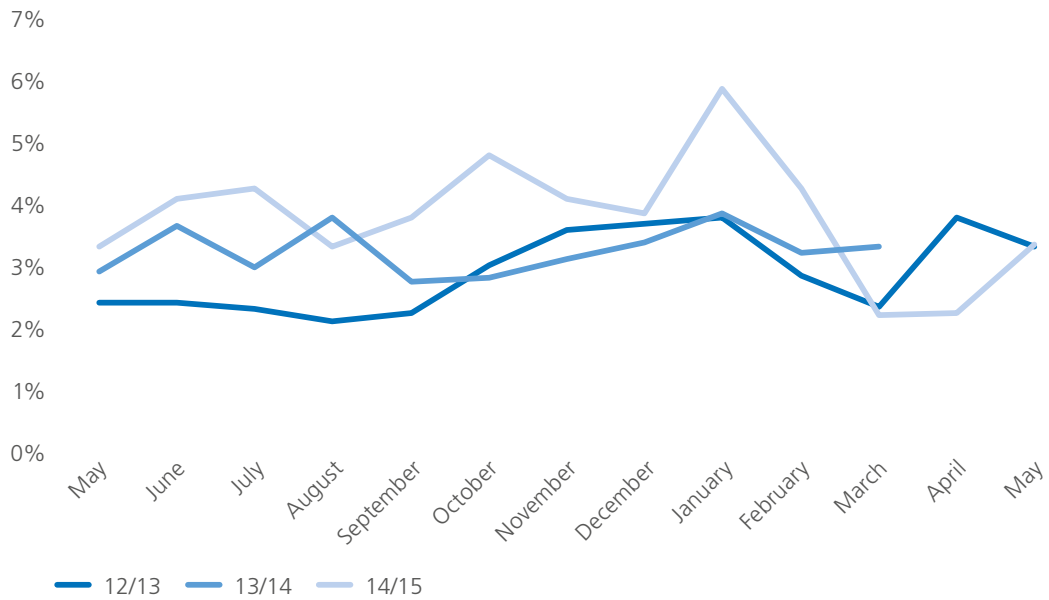
Figure 42 | MAP CAG scores from a selection of questions from the 2015 national staff survey (percentage)



Percentage scores (i.e. percentage of staff giving a particular response to one or a series of survey questions).

Staff sickness rates

Figure 43 | Compares staff sickness over the last three years



Research income for the CAG

MAP researchers have been successful in obtaining research funding from a wide range of funding bodies. The CAG increasingly benefits from prestigious NIHR funding. Since April 2015, MAP researchers have received preliminary approval for up to £5m of further funding.

Figure 44 | Research income for the period August 2010–April 2015

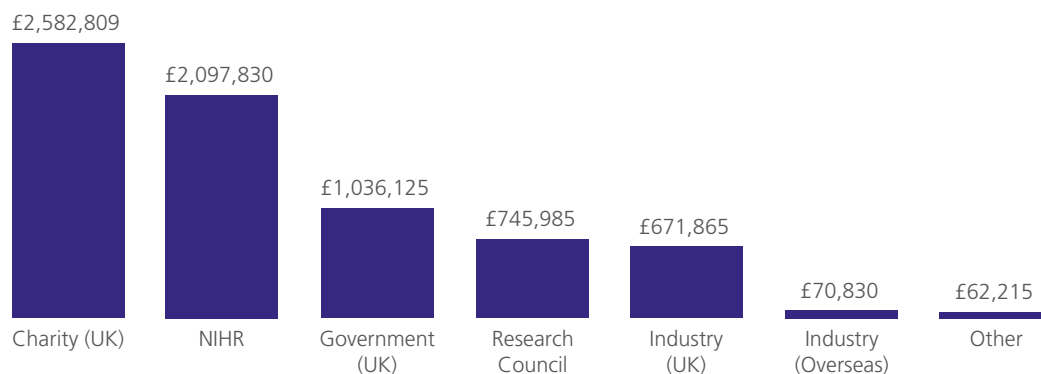
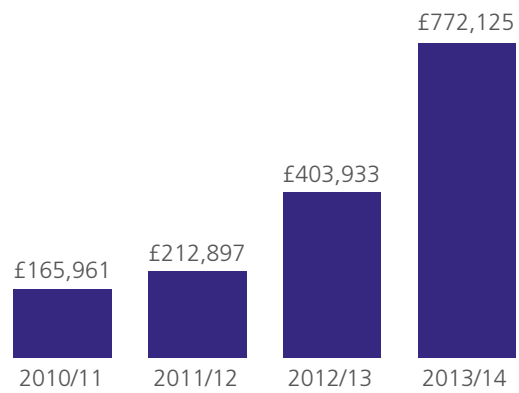


Figure 45 | Funding from the NIHR (by financial year, August–July)



Publications

Selection of published books

Author	Title	Publisher
Moorey, S. & Greer, S.	Oxford Guide to CBT for People with Cancer (2011)	Oxford University Press
Whittington, A., Grey, N. (Eds.)	How to Become a More Effective CBT Therapist: Mastering Metacompetence In Clinical Practice (2014)	Wiley Blackwell
Rimes, K.A. & Chalder, T.	Overcoming chronic fatigue in young people: A cognitive behavioural self-help guide (2015)	Routledge
Soares, J.C. & Young, AH (Eds.)	Bipolar Disorders: Basic Mechanisms and Therapeutic Implications (2016)	Cambridge University Press
Tylee, A. et al.	UPBEAT-UK: a programme of research into the relationship between coronary heart disease and depression in primary care patients (2016)	Southampton (UK): NIHR Journals Library, www.ncbi.nlm.nih.gov/books/NBK363081/

Selection of High Impact Publications in order of publication date	Journal
Hayes, S. et al. (2010). Facilitating a Benign Attentional Bias Reduces Negative Thought Intrusions. <i>119</i> (1), 235–240. doi: 10.1037/a0018264	Journal of Abnormal Psychology
Butts, K.A., et al. (2011). Glucocorticoid receptors in the prefrontal cortex regulate stress-evoked dopamine efflux and aspects of executive function. <i>108</i> , 18459–18464. 10.1073/pnas.1111746108	Proceedings of the National Academy of Sciences of the United States of America
Challacombe, F.L. & Salkovskis, P.M. (2011). Intensive cognitive-behavioural treatment for women with postnatal obsessive-compulsive disorder: A consecutive case series. <i>49</i> (6–7): 422–426. doi: 10.1016/j.brat.2011.03.006	Behaviour Research and Therapy
Oldfield, V. et al. (2011). Time-intensive cognitive behaviour therapy for obsessive-compulsive disorder: A case series and matched comparison group. <i>50</i> (1), 7–18. doi: 10.1348/014466510X490073	British Journal of Clinical Psychology
Tylee, A. et al. (2011). Up-Beat UK: A programme of research into the relationship between coronary heart disease and depression in primary care patients. <i>12</i> , 38. doi: 10.1186/1471-2296-12-38	BMC Family Practice
Arnone, D. et al. (2012). Increased Amygdala Responses to Sad But Not Fearful Faces in Major Depression: Relation to Mood State and Pharmacological Treatment. <i>169</i> (8), 841–850. doi: 10.1176/appi.ajp.2012.11121774	The American Journal of Psychiatry
Borschmann, R., et al. (2013). Joint crisis plans for people with borderline personality disorder: feasibility and outcomes in a randomised controlled trial. <i>202</i> (5), 357–364. doi: 10.1192/bjp.bp.112.117762	British Journal of Psychiatry
Dutta, R., et al. (2012). Mortality in first-contact psychosis patients in the UK: a cohort study. <i>42</i> (8), 1649–1661. doi: 10.1017/S0033291711002807	Psychological Medicine
Fekadu, A., et al. (2012) Prediction of longer-term outcome of treatment-resistant depression in tertiary care. <i>201</i> , 369–375. doi: 10.1192/bjp.bp.111.102665	British Journal of Psychiatry
Fok, M.L. et al. (2012). Life expectancy at birth and all-cause mortality among people with personality disorder. <i>73</i> (2), 104–7. doi: 10.1016/j.jpsychores.2012.05.001	Journal of Psychosomatic Research
Green, S., et al. (2012). Guilt-selective functional disconnection of anterior temporal and subgenual cortices in major depressive disorder. <i>69</i> (10), 1014–1021. doi:10.1001/archgenpsychiatry.2012.135	Archives of General Psychiatry
Moran, P. et al. (2012). The natural history of self-harm from adolescence to young adulthood: a population-based cohort study. <i>79</i> (9812):236–43. doi: 10.1016/S0140-6736(11)61141-0.	The Lancet
Power, R. A. et al. (2012). Dissecting the genetic heterogeneity of depression through age at onset. <i>159B</i> (7), 859–868. Doi: 10.1002/ajmg.b.32093	American Journal of Medical Genetics. Part B: Neuropsychiatric Genetics

Selection of High Impact Publications in order of publication date	Journal
Rane, L.J., et al. (2012). Carer burden in treatment resistant depression: disruption of the cortisol awakening response and relation to treatment outcome. <i>42</i> , 1825–1833. doi: 10.1017/S0033291711003035	Psychological Medicine
Watson, S. et al. (2012). A Randomized Trial to Examine the Effect of Mifepristone on Neuropsychological Performance and Mood in Patients with Bipolar Depression. <i>72</i> (11), 943–949. doi: 10.1016/j.biopsych.2012.05.029	Biological Psychiatry
Borschmann, R., et al. (2013). Joint crisis plans for people with borderline personality disorder: feasibility and outcomes in a randomised controlled trial. <i>202</i> (5), 357–364. doi: 10.1192/bjp.bp.112.117762	British Journal of Psychiatry
Colasanti, A., et al. (2013). Bipolar Disorder is associated with the rs6971 polymorphism in the gene encoding 18kDa Translocator Protein (TSPO). <i>38</i> (11), 2826–2829. doi: 10.1016/j.psyneuen.2013.07.007	Psychoneuroendocrinology
Ehlers, A., et al. (2013) Implementation of Cognitive Therapy for PTSD in Routine Clinical Care: Effectiveness and Moderators of Outcome in a Consecutive Sample. <i>51</i> (11),742–52. doi: 10.1016/j.brat.2013.08.006	Behaviour Research and Therapy
Gallagher, P., et al. (2013). Neurocognitive functioning in bipolar depression: a component structure analysis. <i>44</i> (5), 961–74. doi: 10.1017/S0033291713001487	Psychological Medicine
Green, E. K., et al. (2013). Association at SYNE1 in both bipolar disorder and recurrent major depression. <i>18</i> (5), 614–617. doi: 10.1038/mp.2012.48	Molecular Psychiatry
Juruena, M. F., et al. (2013). The role of mineralocorticoid receptor function in treatment-resistant depression, <i>27</i> (12), 1169–1179. doi: 10.1177/0269881113499205	Journal of Psychopharmacology
Hirsch, C., et al. (2013). Characteristics of worry in Generalized Anxiety Disorder, <i>44</i> (4), 388–395. doi: 10.1016/j.jbtep.2013.03.004.	Journal of Behavior Therapy and Experimental Psychiatry
Power, R. A. et al. (2013). Estimating the heritability of reporting stressful life events captured by common genetic variants. <i>43</i> (9), 1965–1971. doi: 10.1017/S0033291712002589	Psychological Medicine
Stokes, P., et al. (2013). Nature or nurture? Determining the heritability of human striatal dopamine function: an [18F]-DOPA PET study. <i>38</i> (3), 485–491. doi: 10.1038/npp.2012.207	Neuropsychopharmacology: official publication of the American College of Neuropsychopharmacology
Stott, R. et al. (2013). Internet-delivered cognitive therapy for social anxiety disorder: A development pilot series. <i>47</i> (4): 383–397. doi: 10.1017/S1352465813000404	Behavioural and Cognitive Psychotherapy
Andreassen, O. A., et al. (2014). Genetic pleiotropy between multiple sclerosis and schizophrenia but not bipolar disorder: differential involvement of immune-related gene loci. <i>20</i> (2), 207–14. doi: 10.1038/mp.2013.195	Molecular Psychiatry

Selection of High Impact Publications in order of publication date	Journal
Asherson, P., et al. (2014). Differential diagnosis, comorbidity, and treatment of attention-deficit/hyperactivity disorder in relation to bipolar disorder or borderline personality disorder in adults. <i>30(8)</i> , 1657–1672. doi: 10.1185/03007995.2014.915800	Current Medical Research and Opinion
Borsini, A., et al. (2014). Childhood stressors in the development of fatigue syndromes: a review of the past 20 years of research. <i>44(9)</i> , 1809–1823. doi: 10.1017/S0033291713002468	Psychological Medicine
Ehlers, A., et al. (2014). A Randomized Controlled Trial of 7-Day Intensive and Standard Weekly Cognitive Therapy for PTSD and Emotion-Focused Supportive Therapy. <i>171(3)</i> , 294–304. doi: 10.1176/appi.ajp.2013.13040552	The American Journal of Psychiatry
Daly, E., et al. (2014). Response inhibition and serotonin in autism: a functional MRI study using acute tryptophan depletion. <i>137(9)</i> , 2600–2610. doi: 10.1093/brain/awu178	Brain
Fok, M.L., et al. (2014). Predictors of natural and unnatural mortality among patients with personality disorder: evidence from a large UK case register. <i>9(7)</i> . doi: 10.1371/journal.pone.0100979	PLoS One
Fok, M.L. et al. (2014). The impact of co-morbid personality disorder on use of psychiatric services and involuntary hospitalization in people with severe mental illness. <i>49(10)</i> :1631–40. doi: 10.1007/s00127-014-0874-4.	Social Psychiatry and Psychiatric Epidemiology
Grant, N., et al. (2014). Predicting outcome following psychological therapy in IAPT (PROMPT): a naturalistic project protocol. <i>14</i> , 170. doi: 10.1186/1471-244X-14-170	BMC Psychiatry
Horrell, L., et al. (2014). One-day cognitive-behavioural therapy self-confidence workshops for people with depression: randomised controlled trial. <i>204(3)</i> :222–33. doi: 10.1192/bjp.bp.112.121855	British Journal of Psychiatry
Murri, M. B., et al. (2014). HPA axis and aging in depression: Systematic review and meta-analysis. <i>41</i> , 46–62. doi: 10.1016/j.psyneuen.2013.12.004	Psychoneuroendocrinology
Perugi, G., et al. (2015). Mixed features in patients with a major depressive episode: the BRIDGE-II-MIX study. <i>76(3)</i> , e351-8. doi: 10.4088/JCP.14m09092	Journal of Clinical Psychiatry
Rimes, K.A., et al. (2014). Competences Required for the Delivery of High and Low-Intensity Cognitive Behavioural Interventions for Chronic Fatigue, Chronic Fatigue Syndrome/ME and Irritable Bowel Syndrome. <i>42</i> , 760–764. doi: 10.1017/S1352465814000290	Behavioural and Cognitive Psychotherapy
Schrank, B., et al. (2014). A conceptual framework for improving well-being in people with a diagnosis of psychosis. <i>23(4)</i> , 377–387. doi: 10.1017/S2045796013000462	Epidemiology and Psychiatric Sciences
Suzuki, A., et al. (2014). Long term effects of childhood trauma on cortisol stress reactivity in adulthood and relationship to the susceptibility to depression. <i>50</i> , 289–99. doi: 10.1016/j.psyneuen.2014.09.007	Psychoneuroendocrinology

Selection of High Impact Publications in order of publication date	Journal
Taylor, D. M., et al. (2014). Comparative efficacy and acceptability of drug treatments for bipolar depression: a multiple-treatments meta-analysis. <i>130</i> (6), 452–469. doi: 10.1111/acps.12343	Acta Psychiatrica Scandinavica
Veale, D. et al. (2014). Efficacy of cognitive behaviour therapy versus anxiety management for body dysmorphic disorder: A randomised controlled trial. <i>83</i> (6), 341–353. doi: 10.1159/000360740	Psychotherapy and Psychosomatics
Wetzelaer, P., et al. (2014). Design of an international multicentre RCT on group schema therapy for borderline personality disorder. <i>14</i> , 319. doi: 10.1186/s12888-014-0319-3.	BMC Psychiatry
Basilio, R., et al. (2015). Friend engine framework: A real time neuro feedback client-server system for neuro imaging studies. <i>9</i> , [3]. doi: 10.3389/fnbeh.2015.00003	Frontiers in Behavioural Neuroscience
Goddard, E., et al. (2015) The impact of comorbid personality difficulties on response to IAPT treatment for depression and anxiety. <i>73</i> , 1–7. doi: 10.1016/j.brat.2015.07.006	Behaviour Research and Therapy
Henderson, C., et al. (2015). Joint crisis planning in mental health care: The challenge of implementation in randomized trials and in routine care. <i>14</i> , 3, 281–283. doi: 10.1002/wps.20256	World Psychiatry
Mitchell, R., & Phillips, L. H. (2015). The overlapping relationship between emotion perception and theory of mind. <i>70</i> , 1–10. doi: 10.1016/j.neuropsychologia.2015.02.018	Neuropsychologia
Nutt, D. J., et al. (2015). The dopamine theory of addiction: 40 years of highs and lows. <i>16</i> , 305–312. doi: 10.1038/nrn3939	Nature Reviews Neuroscience
Veale, D., et al. (2015). Phenomenology of men with body dysmorphic disorder concerning penis size compared to men anxious about their penis size and to men without concerns: A cohort study. <i>13</i> , 53–61. doi: 10.1016/j.bodyim.2014.09.008	Body Image
Hepgul, N et al. (2016) Clinical characteristics of patients assessed within an Improving Access to Psychological Therapies (IAPT) service: results from a naturalistic cohort study (Predicting Outcome Following Psychological Therapy; PROMPT). <i>16</i> (1), 52. doi: 10.1186/s12888-016-0736-6	BMC Psychiatry
Wise T et al. (2016). Voxel-Based Meta-Analytical Evidence of Structural Disconnectivity in Major Depression and Bipolar Disorder. <i>79</i> (4):293–302. doi: 10.1016/j.biopsych.2015.03.004	Biological Psychiatry

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