Is Bipolar Disorder worked with in NHS Talking Therapies, and what are the views of staff and service users? Results from a linked staff and service user survey and freedom of information request.

Thomas Richardson* (1), Kim Wright (2), Rebecca Strawbridge (3), Jon Wheatley (4), YeeHin Chong (2).

1: Southampton Psychosis and Bipolar Research and Innovation Group, School of Psychology, University of Southampton, Southampton, UK.

2: School of Psychology, University of Exeter, Exeter UK.

3: Centre for Affective Disorders, Department of Psychological Medicine, Institute of Psychiatry, Psychology & Neuroscience, King's College London, London, UK

4: Talking Changes, Homerton Healthcare NHS Trust, London, UK.

*Corresponding author: T.H.Richardson@soton.ac.uk

Short title: Bipolar Disorder and NHS Talking Therapies.

Data Availability Statement: Available upon author request.

Acknowledgements: Thank you to Sarah Owen from Bipolar UK for advertising the survey. Thank you to the NHS trusts audit and service evaluation teams for processing and advertising our survey, and managers for responding for our freedom of information request. Finally thank you to all those took the time to respond to our survey.

Financial support: None.

Conflict of interest statement: TR has been paid through a company he is director of (Richardson Psychological Consultation Ltd.) to deliver training to an NHS Talking Therapies service about working with Bipolar Disorder and will receive royalties from a book he is edited on psychological therapies for Bipolar Disorder. KW receives occasional payments for delivering workshops on psychological therapy for bipolar disorder to clinical and academic organisations. RS has received honoraria from Janssen. JW and YC have no conflicts of interest to declare.

Abstract

Objectives: CBT is effective for Bipolar Disorder (BD), however there is often poor access. Despite IAPT-SMI pilot sites there has been no roll out of CBT for BD in NHS Talking Therapies Services. This study aimed to examine the extent to which BD is seen in these services.

Methods: A survey was conducted of 147 service users with BD and 106 staff. A freedom of information request was also responded to by 48 NHS trusts.

Results: Forty-nine percent of those with BD had tried to access NHS Talking Therapies, with this being prior to a formal diagnosis for 42% of those who had tried to access. 29% were told that they could not be worked with as they had BD. Main reasons for referral were depression followed by anxiety disorders and PTSD. Staff survey and FOI requests showed that relapse prevention work was rarely conducted with BD though comorbid conditions in particular anxiety and PTSD were often treated. BD was rarely routinely screened for, and staff were rarely trained about working with BD specifically. FOI requests showed that a formal BD diagnosis made up only 0.2% of overall referrals, with those with BD being significantly more likely to be discharged after an initial assessment (OR=4.69).

Conclusions: There are few people with a formal BD diagnosis seen within NHS Talking Therapies services, however increased screening may help with earlier diagnosis of those who present with depression. Comorbid anxiety and PTSD are usually worked with in these services. Staff have limited confidence and additional training is warranted.

Keywords: Bipolar, Bipolar Disorder, IAPT, NHS Talking Therapies, Primary Care, Psychological Therapy, CBT.

Is Bipolar Disorder worked with in NHS Talking Therapies, and what are the views of staff and service users? Results from a linked staff and service user survey and freedom of information request.

Introduction

Bipolar Disorder (BD) is a mental health condition affecting around 2% of the population of the United Kingdom (UK) (McManus et al., 2016). In addition to episodes of depression, BD is linked to episodes of hypomania (Bipolar II disorder) or mania (Bipolar 1 disorder), with symptoms including elevated irritable mood, increased energy and activity, racing thoughts and a decreased need for sleep (WHO, 2022). According to the World Health Organisation, BD incurs one of the biggest global burdens in terms of number of healthy years lost (WHO, 2008). BD has a suicide rate 10-30 times the general population (Dome et al., 2019) and 10-12 years reduced life expectancy (Kessing et al., 2015).

Research has demonstrated the effectiveness of psychological therapies for BD, with the most recent meta-analysis of 39 randomised controlled trials showing reduced number of relapses (odds ratio=.56) after psychoeducation delivered via family therapy or in a group setting, with one to one CBT also showing reduced relapse rates (Miklowitz et al., 2021). Cognitive Behavioural Therapy (CBT) (Standardized Mean Difference=-.32), family therapy (SMD=-.46) and interpersonal and social rhythm therapy (SMD=-.46) also reduce depression symptom severity (Miklowitz et al., 2021). The UK National Institute for Clinical Excellence (NICE) reviews evidence on the effectiveness of treatments for specific conditions, to recommend which treatments are offered on the National Health Service (NHS). NICE guidelines clearly state that psychological therapies should be offered in the long-term management of Bipolar disorder in secondary care, with a guidelines of 16-20 sessions being offered (NICE, 2014). Further, NICE recommends that BD is screened for in those presenting

with depression in primary care, and that evidence-based psychological therapies are offered for depression for those with BD, in primary care (NICE, 2014).

However, despite clear NICE guidelines, access to psychological therapies for BD in the UK is inconsistent and often poor: A report by the charity Bipolar UK found that only 69% had ever been offered psychological therapy on the National Health Service (NHS) (in a primary or secondary care setting), 26% had been told that they could not access psychological therapy on the NHS and 49% had had to self-fund their own therapy at some point (Goodwin, 2022b). In addition, many of those with BD in the U.K. go undiagnosed or incorrectly diagnosed for a long time: The average age of first diagnosis is 33 years, and there is an average of 9.8 years between first diagnosis of hypomania/mania and a diagnosis of BD, and 9.5 years between first contact with mental health services and diagnosis with 60% being initially diagnosed with unipolar depression (Goodwin, Dolman, Young, Jones, Richardson & Kitchen, 2021). Thus, there is need for earlier diagnosis and intervention, and greater access to psychological therapy.

NHS Talking Therapies (previously Increasing Access to Psychological Therapies: IAPT) is England's primary care psychological therapies service for mild to moderate common mental health disorders (depression, anxiety disorders, Post-Traumatic Stress disorder). This was established to improve access to evidence-based treatment such as Cognitive Behaviour Therapy (CBT) and has been shown by multiple studies to improve symptoms of depression and anxiety (Wakefield et al., 2021). Services are offered free at the point of delivery and sees around 1.8 million people per year (NHS Digital, 2024).

Bipolar UK found that that only 15% of those with BD had been offered NHS Talking Therapies service specifically and 52% of these had found it helpful; the charity has called for greater access to NHS Talking Therapies for those with BD (Goodwin, 2022b). A recent study which screened 371 participants in a single NHS Talking Therapies service found that 30% of

those presenting for depression and anxiety likely met the criteria for BD, however outcomes from standard therapies were no different (Strawbridge et al., 2022). This suggests a high proportion of BD amongst those who present to NHS Talking Therapies, much of it likely undiagnosed and being treated as unipolar depression. Extrapolating from these figures, of the 1.83 million referrals received by NHS Talking Therapies per year (NHS Digital, 2024), we might expect around 549,000 to have bipolar disorder, which is likely largely undiagnosed.

The IAPT Serious Mental Illness (SMI) demonstration sites aimed to pilot service developments to increase access to evidence-based psychological therapies for psychosis and BD. The BD demonstration site offered a 10-session psychoeducation group 'Mood on Track' which has been used in a specialist Bipolar Disorder service in Birmingham. The research found 81% completion and a medium effect size for improved perceived personal recovery from BD (as measured by the Bipolar Recovery Questionnaire) as well as smaller effect sizes for depression and anxiety symptoms and functioning (Jones et al., 2018). However, this exercise did not include piloting or roll-out of psychological therapies for BD within NHS Talking Therapies specifically. It is unclear to what extent BD is worked in within NHS Talking Therapies services, and what the policies around this currently are. The views and experiences of staff working with BD in these services are also important to study to understand why BD might not be worked with by some services, and what can be done to improve confidence working with this population should NHS Talking Therapies services seek to deliver therapies for people with BD.

This research therefore addressed the following questions:

- What are NHS Talking Therapies staff experiences and views of working with BD within primary care?
- How many of those with BD have had access to NHS Talking Therapies, and what were their experiences of this?

- What are existing policies and practices for working with BD within NHS Talking Therapies?

Method

Design

A survey-based design was used with author-constructed questionnaires. Two separate surveys were designed; one for those with BD amongst the general public (service user survey) and one for staff who were working in NHS Talking Therapies services (staff survey). A freedom of information request was also used to gather data from NHS Talking Therapies services. Copies of the FOI request and survey are shown in the online appendix.

Participants

Adult participants with BD were recruited to take part in the service user survey via social media and the charity Bipolar UK. Inclusion criteria were currently living or having previously lived in England, and self-report of a formal diagnosis of BD made by a health professional. The advert did not mention NHS Talking Therapies specifically, and invited participation regardless of whether or not people had received psychological therapy. A total of 147 participants with BD completed the survey, one was removed due to not completing most questions, and two were removed due to reporting not having formally been diagnosed with Bipolar, leaving 144 participants. Data for the service user survey were collected between January and April 2023. Staff working within NHS Talking Therapies services (Low or High Intensity) were recruited for the staff survey via social media as well as via emails sent through employing NHS organisations. The survey specified that people could take part regardless of what experiences they had had working with bipolar. A total of 118 staff begun the survey, however 10 staff did not answer questions beyond consent and 2 did not answer questions

beyond demographics so were removed leaving a sample size of 106. Data for the staff survey were collected between November 2022 and March 2023.

Freedom of Information requests were sent to all NHS Talking Therapies services identified by NHS digital data set reports (NHS Digital., 2024). Out of 53 requests made, 48 responses from NHS trusts were received. Of these 48 Trusts 17 did not provide information on the number of NHS Talking Therapies services they run and the name or location of those services. From the remaining 31 trusts, a total of 61 NHS Talking Therapies services were identified.

Surveys

The surveys and freedom of information request form were designed by the authors and are shown in the online appendix. All surveys were completed online, the freedom of information request could also be returned via email.

The freedom of information request had 11 questions (with some additional sub-questions within these) about guidelines and policies for working with BD within the service, whether BD is an exclusion criterion, under what circumstances the service would work with people with BD, whether the service routinely screens for BD, staff training in relation to BD, number of BD referrals seen in the past two years and details about number of completions. A free text box was also given to allow respondents to provide more information.

The staff survey had six questions about background and demographics, and 18 questions covering if and under what circumstances BD would be worked with in their service, whether BD is screened for, personal experiences of working with those with BD within NHS Talking Therapies, training received, confidence about working with BD, whether they would want to work more with people with BD, and concerns about this. For all questions additional open text questions asked for more detail.

The service user survey consisted of 8 questions on demographic information and clinical diagnoses as described above, followed by 18 questions on whether they had received psychological therapy in any service and whether they had heard of, accessed or tried to access NHs Talking Therapies. For those who had accessed these services questions asked about whether they were offered therapy, what they were working on (the focus of therapy), what they were offered, number of sessions attended, and how helpful it was found to be.

Ethical Approval

This survey was approved by individual NHS trusts as an evaluation of practice. Ethical approval for the surveys was given by the University of XX ethics committee (*XXXX*).

Analysis

Descriptive statistics were used to summarise quantitative data. An inductive content analysis (Elo & Kyngäs, 2008) was conducted for qualitative data for open ended responses to questions for the staff survey. This was conducted by TR and then the categories discussed and agreed with remaining authors. In terms of a reflexivity statement: TR is a white British male, a clinical psychologist who has worked in the NHS but not in NHS Talking Therapies specifically, and also has lived experience of BD. Where data were missing for individual questions, percentages given below are for those who answered rather than the whole sample. Chi-square was used to test differences in proportion of referrals accepted and completed treatment depending on whether or not they were diagnosed with BD.

Results

Staff Survey

The characteristics of the staff survey are shown in Table 1. The content analysis from the qualitative questions is outlined in Table 2. In terms of service entry criteria 35.8% (*n*=38) of participants reported that those with BD were not eligible for their service, 63.2% (*n*=67) reported that those with BD are eligible in some circumstances and 0.9% (*n*=1) 'Other'. The specific circumstances under which they could work with BD are displayed in figure 1.

Content analysis revealed a category of 'decisions on a case by cases basis', with treatment offered in some circumstances often at managers discretion:

"BP is a exclusion criteria unless reviewed by senior management"

"At the moment, it seems to be a case-by-case situation, but often ruled by risk, complexity, chronicity of current problems and patient's current support network."

There were also comments from staff of 'disagreements and conflicting messages' about suitability for service:

"It has come up recently in duty a few times, even people with old BiPolar diagnoses are not eligible, there has been discussion about the appropriateness of this hard line but as yet very little movement."

17.2% (*n*=17) reported that their service routinely screened for BD in initial assessments, whilst 82.8% (*n*=82) did not. For those who did screen, 35.3% (*n*=6) did so using self-report measures, 76.5% (*n*=13) with structured interview questions, and 23.5% (*n*=4) 'Other'.

In terms of whether they had worked, in their current service and role, with people with BD (whether formally diagnosed or suspected), 27.4% (*n*=29) said no, 49.1% (*n*=52) had for assessment only, 22.6% (*n*=24) had for an anxiety disorder, 7.5% (*n*=8) for PTSD, 19.8% (*n*=21) for current depression work, 2.8% (*n*=3) for relapse prevention work and 0.9% (*n*=1) only when they were under secondary care jointly. 5.7% (*n*=6) reported working with someone with BD on a focus not listed: these included social anxiety and mood regulation.

For those who had worked with people with BD within NHS Talking Therapies (*n*=46), no staff members felt they had better outcomes than other patients in NHS Talking Therapies, 19.6% (*n*=9) felt they had similar outcomes to other patients, 28.2% (*n*=13) felt they had worse clinical outcomes and 52.2% (*n*=24) were not sure. For those who had not worked with BD within NHS Talking Therapies (*n*=67), none felt patients with BD would have better outcomes than other patients in NHS Talking Therapies, 9% (*n*=6) felt they would have similar outcomes to other patients, 11.9% (*n*=8) thought they would have worst outcomes, and 79.1% (*n*=53) were not sure.

For those who had worked with BD within NHS Talking Therapies, in terms of whether they felt those with Bipolar were more or less likely to be re-referred in the future compared to other patients, 8.1% (*n*=5) felt they were less likely to be re-referred, 16.1% (*n*=10) felt there was no difference, 20.9% (*n*=13) felt they were more likely to be re-referred, and 54.8% (*n*=34) were not sure.

In terms of confidence delivering psychological therapy with BD, 38.9% (*n*=37), felt 'not at all confident' 45.3% (*n*=43) felt 'Somewhat confident, or confident with respect to certain presenting issues', 12.6% (*n*=12) felt 'Confident in working with most presenting issues" and 3.2% (n=3) felt 'very confident'.

When asked about training for working with BD, 67.4% (*n*=64) had not received any training, 8.4% (*n*=8) did as part of NHS Talking Therapies training, 12.6% (*n*=12) had post-NHS Talking Therapies qualification, and 11.6% (*n*=11) had in a previous or different role.

When asked if they wanted to work more with BD in their NHS Talking Therapies role: 42.1% (n=40) answered yes, 20% (*n*=19) answered no and 37.9% (*n*=36) were not sure. For those who answered no, reasons given focused around BD being too complex for primary care:

“it’s a severe mental health problem, not a common one which IAPT is designed for. It's a lot more complex then your average depression”

“People with Bipolar disorder should be able to access treatment that is suitable to their presentation. In a primary care setting where we can offer a maximum of 16 sessions the underlying problem will not be addressed.”

There was also a category of feeling under-qualified.

“My qualification and training is specifically to assess and treat people with mild to moderate anxiety and/or depression. I do not think that any kind of bipolar disorder falls into this category. It is not fair on either step 2 clinicians or the patients we work with to expect us to work with presentations we are not trained to work with and that are beyond our capacity”

Related to this was a perception that services were already being over-stretched by more complex cases:

"There is increasingly a push for us to work with people with people who should be seen by staff working in secondary care."

For those who did want to work with BD, previous experience from other settings increased confidence in working with this population:

“i have a core professional qualification and experience in secondary care so would be very happy to work with people with such a diagnosis subject to them being ready to engage in a psychotherapy and there being sufficient support for them should therapy prove destabilising.”

Staff reported the need for specialist training supervision:

"supervision with clinicians who have experience of working with people with bipolar, more training e.g. CBT for Bipolar", and ensuring that treatments are delivered that are appropriate and evidence based for the setting and population: *“Would be happy to use LI interventions with those with bipolar if suitable for the presenting problem""*

“"If there is an evidence-based CBT treatment for bipolar”

An additional question asked about staff about what they felt they would need to be able to work with BD in their service. This identified a category around for a need for specialist training and supervision: “*specific training, specific supervision*” and “"*supervision with clinicians who have experience of working with people with bipolar*”., as well as joint working with secondary care:

“medication being managed effectively, clear plan of how to escalate if the client experiences mania or risk”

“joint working with a CMHT Psychiatrist managing medication, regular MDT reviews”

Finally, staff spoke about needing to change session limits and caseload size to allow for this:

“and the flexibility to extend session beyond the 16 session limit; increased consideration for the level of complexity worked with and as such a decreased caseload to prevent therapist burnout.”

"adjustments to targets"

When asked about if joint working with secondary care would be required, 12% (*n*=11) said this would always be needed, 12% (*n*=11) said this would not necessarily be needed and 76.1% (*n*=70) said this would depend on complexity and risk.

When asked about concerns about working with BD in NHS Talking therapies: 73.6% (*n*=78) said not enough training, 66% (*n*=70) were unsure how to work with mania, 46.2% (*n*=49) felt it would be too risky, 38.7% (*n*=41) felt it would be too complicated and 35.8% (*n*=38) were worried that clients symptoms may not improve.

Service User Survey

The characteristics of participants in the service user surveys are presented in Table 3, along with details of previous therapies received (overall, not just in NHS Talking Therapies). Overall, 61.4% (*n*=47) had heard of NHS Talking Therapies and 49.3% (*n*=69) had tried to access this at some point. Of those who had tried to access NHS Talking Therapies, for 58% (*n*=40) this was then they had a BD diagnosis, for 27.5% (*n*=19) this was before they had a diagnosis, and for 14.5% (*n*=10) they were experiencing symptoms but did not yet have a full diagnosis.

Outcomes from the referral to NHS Talking Therapies are shown in Figure 2. Overall, 28.6% (*n*=18) of those who had tried to access NHS Talking Therapies had been specifically told they were not eligible due to have BD. When asked about disclosing BD when assessed by NHS Talking Therapies, 34.8% (*n*=23) said they were directly asked and disclosed this, 15.2% (*n*=10) said they disclosed this without being directly asked, 6.1% (*n*=4) did not disclose as were not asked, 18.2% (*n*=12) did not have BD at the time and 25.8% (*n*=17) reported 'other'. When asked about what problems they were asking for help with (multiple could be ticked) 58% (*n*=40) reported for depression, 42% (*n*=29) BD including relapse prevention, 46.4% (*n*=32) an anxiety disorder, 26.1% (*n*=18) PTSD, and p8.7% (*n*=6) other.

Of those who were offered an intervention, 79.3% (*n*=23) said that they attend all sessions, 13.8% (*n*=4) attended some and 6.9% (*n*=2) attended none. 20% (*n*=5) reported attending 1-5 sessions, 36% (*n*=9) 5-10 sessions, 20% (*n*=5) 10-15 sessions, 12% (*n*=3) 15-20 sessions and 12% (*n*=3) 20 plus sessions. When asked how much they benefitted from therapy from 0-100 (0= made me feel a lot worse, 50= neutral, 100 made me a feel a lot better) scores ranged 30 to 100 with mean of 71.4 SD=20.8. When asked if they got the help the wanted from the NHS Talking Therapies service, 49.3% (*n*=34) said no, 15.9% (*n*=11) said yes, 24.6% (*n*=17) said they were not sure what they wanted, and 1.4% (*n*=1) said they were not sure. 42.8% (*n*=9) reported they felt their therapist had the right skills for help them with BD, 23.9%

(*n*=5) said did not feel the therapist had the right skills for them, and 33.3% (*n*=7) were not sure.

Freedom of Information request

Of the 78 identified services (61 providing service-level data and 17 Trust-level data), 65.4% (*n*=51) reported having local policies or guidelines on accepting referrals for individuals with BD, 24.4% (*n*=19) said no and 3.8% (*n*=3) said neither yes nor no (missing 6.4% [n=5]). Within this, responses from 13 services indicated that NHS Talking Therapies services are not commissioned or trained to work with individuals with bipolar disorder, citing the NHS Talking Therapies/IAPT manual, local policies, and national guidelines as reasons. Two of these 13 services stated that NHS Talking Therapies services focus only on mild to moderate depression and anxiety disorders. However, three of the 13 services indicated that they would work with clients who have bipolar disorder but are stable and present with NHS Talking Therapies-aligned difficulties, such as stress and anxiety.

Regarding whether bipolar disorder is an exclusion criterion for their service, 28.2% (*n*=22) said that it is, 47.4% (n=37) said that it is not and 16.7% (n=13) said it that it would be assessed on an individual basis (missing 5.1% [n=4]). Specifically, comments indicated that bipolar disorder would be considered an exclusion criterion if it was the major presenting problem and was deemed to be severe and unstable. However, if BD was not the primary issue, and the individual wished to work on symptoms of low mood or anxiety, it would not be an exclusion criterion.

In terms of whether services would work directly with BD, 62.2% (*n*=46) of services reported working with BD only in the context of other issues, such as anxiety or PTSD, 4.1% (*n*=3) reported working with those people with BD specifically or with other presenting issues such as anxiety, and 33.8% (*n*=25) reported not working with BD at all (missing *n*=4 [5%]).

Of the 78 services surveyed, 67% (*n*=52) reported not routinely screening for bipolar disorder during initial assessments, while 28% (*n*=22) did screen (missing n=4 [5.1%]. Most services providing further information stated that they followed a general assessment protocol that involved evaluating patients' mental health records, previous mental health history, referral information, and self-reported symptoms, but without including a specific screening process to identify bipolar disorder. In addition to the general assessment protocol, 22% (*n*=17) used structured interview questions, 5.1% (*n*=4) used self-reported measures (e.g., hypomania checklist), and 3.8% (*n*=2) used a combination of both.

When a patient was suspected of having BD, the responses of services varied, with no standard procedure identified. Common actions included continuing usual treatment, adapting treatment to BD, referring to a GP, referring to secondary care, discussing with a multidisciplinary team/supervisors, and conducting further assessments. Services noted that their response depended on the patient's presentation of bipolar disorder and the point at which it was suspected.

In terms of staff training related to BD, 69.0% (*n*=46) reported they had not trained their staff on this, 18.0% (*n*=14) had, and 18.0% (*n*=14) reported 'Other' (missing *n*=4 [5.1%]).

Providers were asked how many people had been referred, been assessed, started therapy, and had completed therapy within their service over the past two years, and what proportion of these were people with BD. Across all services a total of 592 referrals were received for people with BD out of 2,456,085 in total (0.2% of total referrals). The proportion of referrals rejected prior to assessment did not differ between those with (*n*=76/592: 12.8%) and without (*n*=270386/2455493: 11.0%) BD, χ^2=2.01, *df*=1, *p*=0.156. Of those referrals accepted, patients with BD were significantly more likely to be offered an assessment and then discharged (*n*=232 / 516: 45.0%), compared to those without BD (*n*=209665 / 2185107: 9.6%), χ^2=463.52, *df*=1, *p*=<.001, representing an Odds Ratio of 4.69. Of those who went on to enter

treatment, the proportion of those completing treatment did not differ between those with (n=130/153: 85.0%) and without (*n*=822684/1019282: 80.7%) BD, χ^2=0.19, *df*=1, p=0.667.

Discussion

This study aimed to use surveys and freedom of information requests to determine the extent to which Bipolar Disorder (BD) is seen within NHS Talking Therapies, patient experiences of this, and the views and experiences of staff. Overall, around half of those with BD had tried to access these services at some point. Participants reported variation in the treatments offered and perceived benefits of this, though 29% had been told that they could not be seen due to having BD, in line with the staff surveys and FOI request that many services reject referrals of people with BD under all circumstances. An important finding here is the wide variation between services and individuals in their policies and experiences in working with BD.

Despite NHS Talking Therapies being a programme covering the whole of England there seems to be an inconsistent approach to working with BD across services. Even within services there appeared to be a lack of clarity and inconsistency on policies at times. It may therefore be helpful for there to be a more consistent approach, and written guidelines may help with this. Bipolar UK have recommended a national Clinical Director of Mood Disorders be appointed, along with 'Bipolar champions' in each trust (Goodwin, 2022a): Such leadership nationally and within individual NHS Talking Therapies organisations specifically may be helpful. Staff also reported lack of training and low confidence in working with BD, though around half were keen to work more with BD in their role, suggesting that BD specific training may be useful may be useful. The service managed by author JW has a BD champion and lead clinician for their trust which may also prove a useful model for other services. An NHS

Talking Therapies positive practice guide for working with BD may also prove useful to allow for consistency in the approach taken across England.

Some individuals reported wanting help for BD specifically, and FOI and staff surveys showed that most NHS Talking Therapies do not offer relapse prevention work. However, the largest presenting problem reported was depression rather than (hypo)mania, followed closely by anxiety disorders and PTSD. This was in line with the findings of our staff survey and FOI requests showing most staff and services would work with comorbid issues in BD rather than BD per se, and that only around a fifth of staff had worked with Bipolar depression in their role. It is interesting to note that staff reported greater willingness and experience in relation to working with bipolar depression than in relation to BD relapse prevention work, given that there is strong evidence for psychological therapies reducing the risk of relapse (Miklowitz et al., 2021), but a less extensive evidence base for the effect on acute symptoms of depression (Yilmaz et al., 2022). It is however important to note that an analysis in NHS Talking Therapies showed no difference in depression symptom reductions post-treatment in those with or without BD (Strawbridge et al., 2023), so staff should not be discouraged from working with BD clients.

Staff also reported a willingness to work on PTSD within BD, despite there being limited evidence about Eye-Movement Desensitization or prolonged exposure within this population (Katz et al., 2024; Perlini et al., 2020). This is not to say that these treatments should not be offered in NHS Talking Therapies, but rather that it could be argued that if the strongest evidence base were to be followed, relapse prevention therapies would be included in those therapies offered to people with BD. Most services users with BD also presented with multiple problems to these services presenting a further potential challenge for staff and services. It is important to note that the majority (79.3%) of those offered therapy reported attending all sessions, suggesting good engagement. However, only 25% had been offered 15 plus sessions

comparable to the 16-20 recommended by NICE guidelines, linking with qualitative comments from staff about treatment length needing to be extended for those with BD. A related finding is that there were relatively high ratings on how helpful the service was, yet only half reported getting the help they wanted. This may link to the finding that services usually focus on an accompanying problem such as anxiety or PTSD: It might be that those with BD find the service useful for anxiety issues, even if they were unable to work on BD per se as part of that same work.

The overall proportion of referrals for those with diagnosed with BD was very low at 0.2%. Given the estimated 2% prevalence for BD in the UK (McManus et al., 2016), and a lifetime prevalence of comorbid anxiety disorders in BD of 45% (Pavlova et al., 2015), it appears that those with formally diagnosed BD are under-represented in NHS Talking Therapies services. For 42% of those who had accessed NHS Talking Therapies services, this was reported to have been prior to their diagnosis of BD. This is in keeping with previous research suggesting a high level of largely undiagnosed BD within NHS Talking Therapies services (Strawbridge et al., 2023), and the finding from the current study that only a minority of services routinely screen for BD.

This suggests that there may be large numbers of people under NHS Talking Therapies with BD which is undiagnosed, or who are at risk of developing BD in the future. An important clinical implication of this is that training should be given to staff to help them to recognise BD symptoms; this may help reduce the current nearly decade that it takes to obtain a BD diagnosis in the UK (Goodwin, Dolman, Young, Jones,. Richardson, & Kitchen, 2021). However, an important consideration is that it may not be helpful to screen for BD if this means a referral to secondary care which may include longer waiting times, and poor access to psychological therapies for BD (Goodwin et al., 2022), and work is also needed to improve access within secondary care. It is also important to note that measures such as the Mood

Disorder Questionnaire and Hypomania Checklist have relatively poor sensitivity and specificity (Wang et al., 2019), and NICE guidelines specifically say not to screen for BD using questionnaires in primary care (Excellence., 2014). Structured interviews are likely to be too time intensive for already lengthy assessments, therefore how best to screen in NHS Talking Therapies services requires further consideration and research. It is also important to be wary of the already high existing demands on services and staff, with possible high levels of burnout in trainees (Owen et al., 2021), thus additional demands may not be acceptable or feasible for some services and staff.

A feasibility trial has been conducted in younger adults and adolescents using CBT for those at risk of developing BD (Jones et al., 2021), and a large randomised controlled trial is ongoing. There is also a trial of working with those with psychotic experience in NHS Talking Therapies (Ashford et al., 2022). It may therefore be possible in the future for NHS Talking Therapies to provide preventative interventions for younger adults presenting with depression who are at risk of developing BD.

A strength of this study was triangulating data from staff and service user surveys and a freedom of information request. The high response rate for this request means that the results are likely representative of all NHS Talking Therapies services in England. This study is limited by a relatively small sample size for the surveys, with not all regions of England represented equally, and self-reported diagnosis. There was also no data collected on age and ethnicity, which is important given Black services users with BD were less likely to be offered CBT than white service users (Morris et al., 2020). Despite the study being advertised widely and having with broad inclusion criteria there is the possibility of a response bias with service users who have access NHS Talking Therapies, and staff who have worked with BD, being more likely to participate. The limited qualitative data collected via a questionnaire allowed for

a basic content analysis, however further research using focus groups would allow for a richer and more detailed exploration of views.

In conclusion, this study suggests that although official numbers of those with BD accessing NHS Talking Therapies are low, many individuals with BD have tried to access these, often prior to a formal diagnosis. There is limited screening within these services and many with BD may be being missed in primary care. There is an inconsistent approach to whether BD is treated in these services, and comorbid problems are worked with more often than BD per se, despite this being at odds with the weight of evidence from randomised clinical trials. Staff have limited training and confidence, but many are keen to do more work with this patient group so enhanced training is indicated. Future research could consider the benefits of training staff, of including screening for BD and of offering BD-specific therapy protocols on the number of those with BD identified and successfully treated within primary care in the UK. This may help both reduce the time taken to diagnosis as well as improve therapy access for this population.

References

Ashford, P.-A., Knight, C., Heslin, M., Clark, A. B., Kanaan, M., Patel, U., Stuart, F., Kabir, T., Grey, N., & Murray, H. (2022). Treating common mental disorder including

psychotic experiences in the primary care improving access to psychological therapies programme (the TYPPEX study): Protocol for a stepped wedge cluster randomised controlled trial with nested economic and process evaluation of a training package for therapists. *BMJ open*, *12*(6), e056355.

Dome, P., Rihmer, Z., & Gonda, X. (2019). Suicide Risk in Bipolar Disorder: A Brief Review. *Medicina (Kaunas)*, *55*(8), 403. https://doi.org/10.3390/medicina55080403

Elo, S. & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, 62(1), 107-15.

Goodwin, G., Dolman, C., Young, A., Jones, I., Richardson, T., & Kitchen, S. (2022). Hidden in plain sight: the second interim report from the Bipolar Commission.

Goodwin, G., Dolman, C., Young, A., Jones, I. Richardson, T & Kitchen, S. (2021). *Bipolar Diagnosis Matters: "A light in the dark" The early findings of the Bipolar Commission*. https://www.bipolaruk.org/Handlers/Download.ashx?IDMF=afa4ab1e-eb99-4a6e-8af1-79f4472d25e5

Goodwin, G., Dolman, C., Young, A., Jones, I. Richardson, T & Kitchen, S. . (2022a). *Bipolar Minds Matter: Quicker diagnosis and specialist support for everyone with bipolar*. https://www.bipolaruk.org/Handlers/Download.ashx?IDMF=d4fd68a7-ffae-42bb-acf4-f7be3d903f02

Goodwin, G., Dolman, C., Young, A., Jones, I. Richardson, T & Kitchen, S. . (2022b). *Hidden in plain sight: A lived experience report by Bipolar UK.* https://www.bipolaruk.org/Handlers/Download.ashx?IDMF=6859f497-de2c-40db-b6f6-11db73df0fd0

Goodwin, G., Dolman, C., Young, A., Jones, I. Richardson, T & Kitchen, S. . (2021). *Bipolar Diagnosis Matters " A light in the dark": A look at the early findings of the Bipolar*

Commission. https://www.bipolaruk.org/Handlers/Download.ashx?IDMF=afa4ab1e-eb99-4a6e-8af1-79f4472d25e5

Jones, S. H., Akers, N., Eaton, J., Tyler, E., Gatherer, A., Brabban, A., Long, R., & Lobban, F. (2018). Improving access to psychological therapies (IAPT) for people with bipolar disorder: Summary of outcomes from the IAPT demonstration site. *Behav Res Ther, 111*, 27-35. https://doi.org/10.1016/j.brat.2018.09.006

Jones, W. T., Peters, S., Byrne, R. E., Shiers, D., Law, H., & Parker, S. (2021). "It felt very special, it felt customised to me"—A qualitative investigation of the experiences of participating in a clinical trial of CBT for young people at risk of bipolar disorder. *Psychology and Psychotherapy: Theory, Research and Practice*, *94*(3), 686-703.

Katz, D., Petersen, T., Rabideau, D. J., Stark, A., Pintro, K., Alvarez-Hernandez, A., Stancroff, N., Deng, Y., Albury, E., & Kuperberg, M. (2024). A trial of prolonged exposure therapy for outpatients with comorbid bipolar disorder and posttraumatic stress disorder (PTSD). *Journal of affective disorders*, *344*, 432-439.

Kessing, L. V., Vradi, E., & Andersen, P. K. (2015). Life expectancy in bipolar disorder. *Bipolar disorders*, *17*(5), 543-548.

McManus, S., Bebbington, P. E., Jenkins, R., & Brugha, T. (2016). *Mental health and wellbeing in england: The adult psychiatric morbidity survey 2014*. NHS digital.

Miklowitz, D. J., Efthimiou, O., Furukawa, T. A., Scott, J., McLaren, R., Geddes, J. R., & Cipriani, A. (2021). Adjunctive Psychotherapy for Bipolar Disorder: A Systematic Review and Component Network Meta-analysis. *JAMA psychiatry*, *78*(2), 141-150. https://doi.org/10.1001/jamapsychiatry.2020.2993

Morris, R. M., Sellwood, W., Edge, D., Colling, C., Stewart, R., Cupitt, C., & Das-Munshi, J. (2020). Ethnicity and impact on the receipt of cognitive-behavioural therapy in people

with psychosis or bipolar disorder: an English cohort study. *BMJ open*, *10*(12), e034913. https://doi.org/10.1136/bmjopen-2019-034913

NHS Digital (2024). NHs Talking Therapies, for anxiety and depression,Annual reports, 2023-24. *https://digital.nhs.uk/data-and-information/publications/statistical/nhs-talking-therapies-for-anxiety-and-depression-annual-reports/2023-24*.

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-talking-therapies-for-

NICE. (2014). Bipolar disorder: the NICE guideline on the assessment and management of bipolar disorder in adults, children and young people in primary and secondary care. https://www.nice.org.uk/guidance/cg185/chapter/Introduction

Owen, J., Crouch-Read, L., Smith, M., & Fisher, P. (2021). Stress and burnout in Improving Access to Psychological Therapies (IAPT) trainees: a systematic review. *the Cognitive Behaviour Therapist*, *14*, e20.

Pavlova, B., Perlis, R. H., Alda, M., & Uher, R. (2015). Lifetime prevalence of anxiety disorders in people with bipolar disorder: a systematic review and meta-analysis. *The Lancet Psychiatry*, *2*(8), 710-717.

Perlini, C., Donisi, V., Rossetti, M. G., Moltrasio, C., Bellani, M., & Brambilla, P. (2020). The potential role of EMDR on trauma in affective disorders: a narrative review. *Journal of Affective Disorders*, *269*, 1-11.

Strawbridge, R., Alexander, L., Richardson, T., Young, A. H., & Cleare, A. J. (2022). Is there a 'bipolar iceberg'in UK primary care psychological therapy services? *Psychological Medicine*, 1-10.

Strawbridge, R., Alexander, L., Richardson, T., Young, A. H., & Cleare, A. J. (2023). Is there a 'bipolar iceberg'in UK primary care psychological therapy services? *Psychological Medicine*, *53*(12), 5385-5394.

Wakefield, S., Kellett, S., Simmonds-Buckley, M., Stockton, D., Bradbury, A., & Delgadillo, J. (2021). Improving Access to Psychological Therapies (IAPT) in the United Kingdom: A systematic review and meta-analysis of 10-years of practice-based evidence. *British Journal of Clinical Psychology*, *60*(1), 1-37.

Wang, Y. Y., Xu, D. D., Liu, R., Yang, Y., Grover, S., Ungvari, G. S., Hall, B. J., Wang, G., & Xiang, Y. T. (2019). Comparison of the screening ability between the 32-item Hypomania Checklist (HCL-32) and the Mood Disorder Questionnaire (MDQ) for bipolar disorder: A meta-analysis and systematic review. *Psychiatry research*, *273*, 461-466. https://doi.org/10.1016/j.psychres.2019.01.061

WHO. (2008). *The global burden of disease: 2004 update*. World Health Organization.

WHO. (2022). *International Classification of Diseases 11th Edition.* World Health Organisation.

Yilmaz, S., Huguet, A., Kisely, S., Rao, S., Wang, J. L., Baur, K., Price, M., O'Mahen, H., & Wright, K. (2022). Do psychological interventions reduce symptoms of depression for patients with bipolar I or II disorder? A meta-analysis. *Journal of affective disorders*, *301*, 193-204. https://doi.org/10.1016/j.jad.2021.12.112

Table 1

Participant Characteristics for Staff

Gender	
Male	13.2% (*n*=14)
Female	86.8% (*n*=92)
Role	
High Intensity	68.9% (*n*=73)
Low Intensity	27.4% (*n*=29)
Other/Operational	3.8% (*n*=4)
Length of Experience in NHS Talking Therapies	
Currently in training	11.3% (*n*=12)
Two years or less	13.2% (*n*=14)
5 years or less	26.4% (*n*=28)
Over 5 years	49.1% (*n*=52)
Interventions offered	
Low Intensity	35.8% (*n*=38)
Group interventions	52.8% (*n*=56)
CBT	72.6% (*n*=77)
Interpersonal therapy	5.7% (*n*=6)
Behavioural Activation	57.5% (*n*=61)
Mindfulness-based cognitive therapy	7.5% (*n*=8)
Counselling	4.7% (*n*=5)
Eye-Movement Desensitization Reprocessing	18.9% (*n*=20)
Area lived	
Urban	58.5% (*n*=62)

Rural	41.5% (*n*=44)
Region of England	
South East	31.1% (*n*=33)
South West	28.3% (*n*=30)
London	16% (*n*=17)
West Midlands	12.3% (*n*=13)
East Midlands	5.7% (*n*=6)
North East	3.8% (*n*=4)
East of England	1.9% (*n*=2)
Not reported	0.9% (*n*=1)

Table 2

Content analysis for staff survey qualitative questions

Category	Illustrative Quotes
Decisions on a case by case basis	*“BP is a exclusion criteria unless reviewed by senior management”* *"Has to be case by case"* *"Highly assessed before intervention was offered and a lot of consultation work done"* *“At the moment, it seems to be a case-by-case situation, but often ruled by risk, complexity, chronicity of current problems and patient's current support network.”* *"BP is a exclusion criteria unless reviewed by senior management"* *"I know that there have been the odd occasion where this has been offered but its not a rule and usually pushed back against.* *"Our service usually acts on a 'case by case' basis to judge whether we can offer support"* *"At the moment, it seems to be a case-by-case situation"*
Disagreement and conflicting messages	*“It has come up recently in duty a few times, even people with old BiPolar diagnoses are not eligible, there has been discussion about the appropriateness of this* *hard line but as yet very little movement.”* *"We have only recently had clarity about treating people who are managing their Bi polar well"* *"Initially we were always told we must not work with anyone that has bipolar ...We were then told we could work with someone with a dignosis but no recent episodes..* *...My colleagues and I now have no idea what the policy is and senior managers don't seem to know either as they all seem to disagree…"* *"I'm content with bipolar being treated by more specialised, multidisciplinary services rather than in a target pressured iapt service"*

Too complex for primary care	*“it’s a severe mental health problem, not a common one which IAPT is designed for. It's a lot more complex then your average depression”* *“People with Bipolar disorder should be able to access treatment that is suitable to their presentation. In a primary care setting where we can offer a maximum of 16* *sessions the underlying problem will not be addressed.”* *"It’s too much for primary care"* *"I'm content with bipolar being treated by more specialised, multidisciplinary services rather than in a target pressured iapt service"* *"We don't provide a mental health assessment or monitoring role or meds review, we are iapt clinicians working in isolation, we are not providing a role of care co-ordination"* *"we are a 12 session service and i don't know this is suitable for the most part."*
Under-qualified	*"It is not fair on either step 2 clinicians or the patients we work with to expect us to work with presentations we are not trained to work with and that are* *beyond our capacity."* *With no training we are not equipped to work with this disorder in a beneficial way for clients.* *At step 2 I don't feel I have the experience or training to work with clients with bipolar.*
Services already stretched	*"There is so much pressure on IAPT to see people with needs that are greater than the service is designed or resourced to treat"* *"There is increasingly a push for us to work with people with people who should be seen by staff working in secondary care."*
Confidence from previous work with BD	*Only a few months into training in this role within IAPT. Have previously worked with many clients with a Bi-Polar diagnosis as a mental health supported living services* *manager, most of whom were also supported by secondary mental health services.* *“i have a core professional qualification and experience in secondary care so would be very happy to work with people with such a diagnosis subject to them being ready to engage in a psychotherapy and there being sufficient support for them should therapy prove destabilising.”* *"I have worked with people with bipolar in secondary care."*

	"I ahve (sic) worked with bipolar disorder in other roles and would like to be able to offer CBT to this group" *"I am confident working with people with bipolar from a previous role"*
Appropriateness and evidence base of treatments	*"I am also unsure of the evidence based and effectiveness of the low intensity interventions for this client group."* *"If an intervention were determined to be appropriate in supporting patients with Bipolar disorder and I recieved training on how to best support this* *patient group then I would be happy to work with this patient group."* *"Yes if appropriate training given"* *"I'd like training on working with people with bipolar and would be happy to use LI interventions with those with bipolar if suitable for the presenting problem"* *"If there is an evidence base for treating Bipolar in Primary Care, yes I would."* *"If there is an evidence based CBT treatment for bipolar I think it would be great to deliver this in IAPT as there are limited options for people with bipolar in this* *borough outside of medication"* *"Cleary defined goals and treatment model, NICE guidance"*
Specialist training and supervision	*"More supervision"* *"Training in screening for suitability, what to look out for, what not to do, close supervision"* *"Have regular supervision specific to bipolar,"* *"Appropriate training; supervision"* *"supervision with clinicians who have experience of working with people with bipolar, more training e.g. CBT for Bipolar"* *"supervision from secondary care."* *I would like to have the option particularly with additional formal training like the top up SMI CBT IAPT course*

Joint working with secondary care	*"I think care should be joined up, I think theres a lot of scope for people to be able to be treated for bipolar and psychosis in IAPT given that they are also under secondary care"* *"Yes if appropriate training given and joint working with secondary care was available if appropriate"* *training on CBT for bipolar and an agreement on what IAPT bipolar looks like and what CMHT bipolar looks like that both services sign up to with a manger high enough to* *ensure both services comply with the agreement"* *"medication being managed effectively, clear plan of how to escalate if the client experiences mania or risk"* *"Joint working so additional support can be accessed promptly for patients if required"* *"joint working with a CMHT Psychiatrist managing medication, regular MDT reviews"* *Links to secondary care to enable any concerns about deterioration in mental health to be actioned quickly.*
Changing session limits and caseload	*"adjusted clinical hours expectations"* *"Flexibility to extend session beyond the 16 session limit..increased consideration for the level of complexity worked with and as such a decreased caseload to prevent* *therapist burnout."* *"adjustments to targets"*

Table 3

Participant Characteristics for Service Users

Gender	
Male	13.2% (*n*=14)
Female	86.8% (*n*=92)
Role	
High Intensity	68.9% (*n*=73)
Low Intensity	27.4% (*n*=29)
Other/Operational	3.8% (*n*=4)
Length of Experience in NHS Talking Therapies	
Currently in traning	11.3% (*n*=12)
Two years or less	13.2% (*n*=14)
5 years or less	26.4% (*n*=28)
Over 5 years	49.1% (*n*=52)
Interventions offered	
Low Intensity	35.8% (*n*=38)
Group interventions	52.8% (*n*=56)
CBT	72.6% (*n*=77)
Interpersonal therapy	5.7% (*n*=6)
Behavioural Activation	57.5% (*n*=61)
Mindfullness-based cognitive therapy	7.5% (*n*=8)
Counselling	4.7% (*n*=5)
Eye-Movement Desensitization Reprocessing	18.9% (*n*=20)
Area lived	
Urban	58.5% (*n*=62)

Rural	41.5% (*n*=44)
Region of England	
South East	31.1% (*n*=33)
South West	28.3% (*n*=30)
London	16% (*n*=17)
West Midlands	12.3% (*n*=13)
East Midlands	5.7% (*n*=6)
North East	3.8% (*n*=4)
East of England	1.9% (*n*=2)
Not reported	0.9% (*n*=1)
Ever had psychological therapy	
Yes	93.7% (*n*=134)
No	6.3% (*n*=9)
How many different courses therapy received	
1	14.2% (*n*=19)
2-5	57.5% (*n*=77)
6 or more	24.6% (*n*=33)
Not sure	3.7% (*n*=5)
Ever started therapy but not finished	
Yes	39.6% (*n*=53)
No	53% (*n*=71)
Not sure	7.5% (*n*=10)
Where therapy was accessed from	
NHS hospital, secondary care or community mental health team	70.1% (*n*=94)
NHS Talking Therapies (Self-referral or GP referral)	44% (*n*=59)

In another country	6.7% (*n*=9)
Privately (self-funded or through insurance)	59% (*n*=79)
Through a charity	22.4% (*n*=30)
Through work	18.7% (*n*=25)
Other	6.7% (*n*=9)
What type of therapy received	
Counselling	73.1% (*n*=98)
Mindfulness based cognitive therapy	31.3% (*n*=42)
Self-help	30.6% (*n*=41)
Group based psychoeducation/relapse management	30.6% (*n*=41)
Other	26.9% (*n*=36)
Another group therapy (such as DBT)	12.7% (*n*=17)
Interpersonal therapy	11.2% (*n*=15)
Behavioural Activation	4.5% (*n*=6)

Figure 1

Staff reported circumstances in which they could work with BD (n=106)

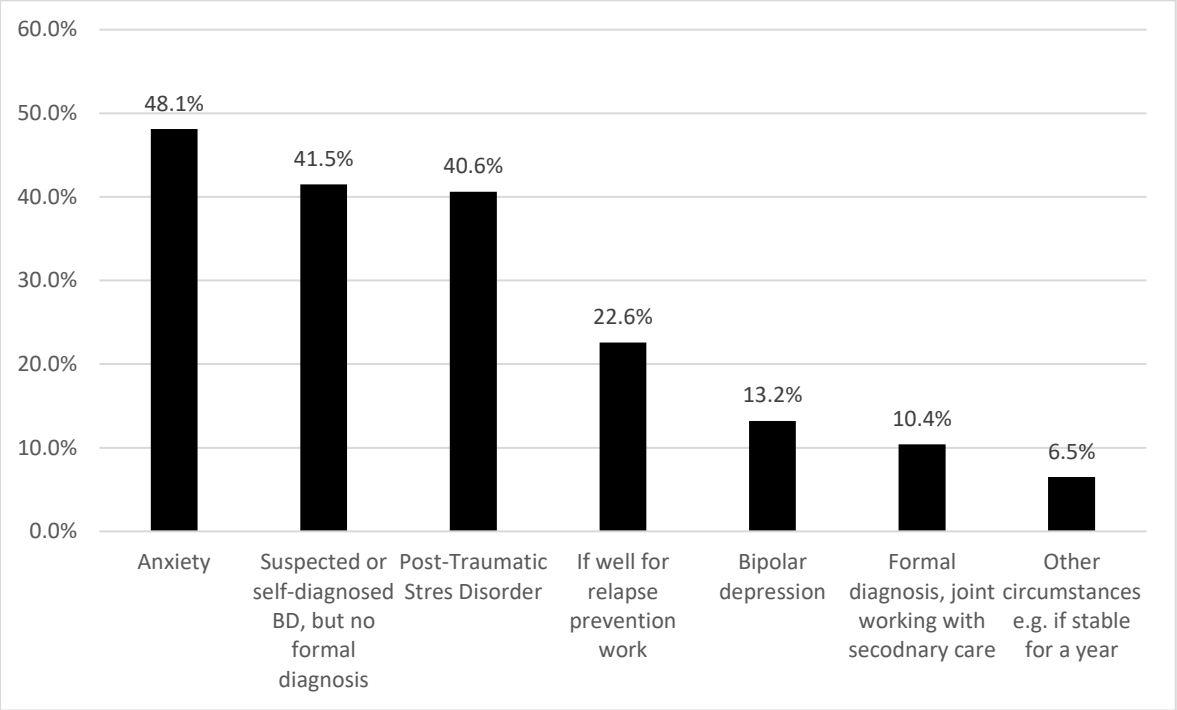

Figure 2

Service user reported outcomes from NHS Talking Therapies referral (n=147)