Improving Access to Psychological Therapies

IAPT

Guidance for Commissioning IAPT Training

2011/12 – 2014/15

IAPT Programme
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EXECUTIVE SUMMARY

On 2 February 2011, the Government published No health without mental health, which sets out the strategy for improving the mental health and well-being of the nation. Central to this strategy is the Government’s commitment that the NHS will complete nationwide roll-out of Improving Access to Psychological Therapies (IAPT) services between 2011/12 and 2014/15.

The Talking Therapies: A four-year plan of action was published in conjunction with the mental health strategy and outlines how the 2010 Spending Review commitment to expand access to psychological therapies will be achieved. Specifically, the Department of Health financial settlement in the Spending Review 2010 rises in cash terms and includes around £400 million for psychological therapies over the period to April 2015. The NHS has already been notified of PCT allocations for 2011-12 which included additional funding for increasing access to talking therapies. Funding will continue to increase to enable PCTs to realise this commitments and will amount to an additional £400 million over the spending review period on top of the annual allocation of £173m from the first phase of the programme which will continue.

Changes to the NHS architecture set-out in Liberating the NHS: Developing the healthcare workforce during this phase of the programme mean that a new route for the funding to flow into the system is essential. The Multi Professional Education and Training (MPET) service level agreement has been identified by the Department of Health and NHS Finance as the most appropriate route. Included within the new funding announcement is the commitment that the education, training and some salary costs will be met from within the MPET budget.

This commitment involves regional commissioning of Cognitive Behavioural Therapy, High Intensity and Psychological Wellbeing Practitioners (PWPs) training places to a national total of approximately 800 per year for three years. Currently this training which is generally at a postgraduate level, involves one or two days a week at a university and three or four days delivering supervised practice, treating clients with depression and anxiety disorders. In addition, it involves regional commissioning of training for approximately 240 already-qualified therapists per annum in four disciplines that are also approved by the National Institute for Health and Clinical Excellence (NICE) for the treatment of these common mental health problems.

Precise numbers of trainees in each area are for local determination. Support, advice and guidance continues to be available from a central IAPT team which has been fulfilling this function for three years, during which time the CBT training has been commissioned regionally by Strategic Health Authority IAPT teams, usually (but not always) working with SHA Workforce Leads.

Alongside completing the roll-out of IAPT services, the Spending Review settlement allows some limited central funding to begin work on other policy strands that also focus on expanding access to psychological therapies. These relate to children and young people, people with long-term physical conditions or medically unexplained symptoms, people with severe mental illness, and older people.

As the reorganisation of the NHS unfolds over the next few years, new arrangements will have to be developed to continue commissioning all the IAPT training needed and to take account of future changes. These will include a reduction in dedicated Regional IAPT teams, the closure of SHAs and PCTs and the introduction of GP Commissioning Consortia and any changes that may emerge following the publication of the White Paper currently under consultation.
Where the term SHA has been referred to throughout this document, subject to this consultation it is recognised that education commissioning agents will emerge in the future and will ultimately replace SHAs.

1. PURPOSE AND STRUCTURE

1.1 The purpose of this document is as a guide for education and training commissioners of the Improving Access to Psychological Therapies (IAPT) workforce via the Multi Professional Education and Training (MPET) allocation.

1.2 The key workforce aims of the programme are to:
- complete the nationwide roll-out of the IAPT training programme
- develop programmes to support the Government’s expanded approach to psychological therapies and a choice of psychological therapy.
- develop a long term sustainable programme of education and training for the future of IAPT services.

1.3 The document outlines the background to the IAPT programme and provides a number of references to documents and further information available on the IAPT website and elsewhere. (www.iapt.nhs.uk)

1.4 The document should be read in conjunction with the MPET Service Level Agreement 2011/12 (when published) and other documents identified.

1.5 A summary of the projected number of training places and the funding arrangements MPET will cover in 2011/12 appears at Annex 1.

1.6 The document contains a description of an IAPT service, the proposed number of IAPT trained staff and suggestions on how to maximise the benefit of the funding available via MPET.

1.7 In recognition of the numerous competing demands on NHS resources and MPET, during this transitional period, this document suggests options for flexible and efficient implementation by commissioning authorities.

2. INTRODUCTION AND OVERVIEW

2.1 Background to the IAPT programme
The Improving Access to Psychological Therapies programme began in October 2007 when the Government announced annual investment rising to £173m by 2010/11 to fund the roll-out of evidence-based psychological therapy services across England for people experiencing depression and anxiety disorders. The treatments offered are those approved by the National Institute of Health and Clinical Excellence (NICE) for treating these common mental health problems.

The investment was the first phase of what was expected to be a six-year implementation phase, establishing training courses, services and new IT and workforce infrastructures around the country. By March 2011 approximately:
- 60 per cent of the population will have access to IAPT services
- 3,600 whole-time equivalent (WTE) new psychological therapy workers will have been trained
• 400,000 people will have received evidence-based, NICE-approved psychological therapies for depression and anxiety disorders

By September 2010 (the latest figures available):
• 72,000 people moved to recovery and
• 14,000 of those treated came off sick pay and benefits and started or returned to work.

This has been achieved through 10 Strategic Health Authority (SHA) IAPT teams based regionally to co-ordinate the work in conjunction with their local Primary Care Trusts. These teams have been commissioning the training places, in many cases in conjunction with their SHA Workforce Lead colleagues for three years. In turn, the 10 regional teams have been guided and overseen by a small central team acting for and on behalf of SHAs, based at the Department of Health. A key part of the programme has been to develop a competent workforce to deliver the stepped care model, in line with NICE guidance (shown in Annex 2).

To date implementation has focused on the recruitment and training of a new workforce of psychological therapists trained in Cognitive Behavioural Therapy (CBT). This was because CBT is the principal treatment approved by NICE for anxiety disorders and one of the principal treatments approved for depression. Evidence shows CBT is as cost-effective as medication – and better at preventing relapse. Despite this, it had the biggest deficits in terms of the availability of a suitably trained workforce. Each year, funds held centrally, for and on behalf of SHAs, have been distributed to the regions in response to robust local and regional plans to establish IAPT services.

One-year training courses for:
• High Intensity Therapy workers and
• Psychological Wellbeing Practitioners (formerly known as Low Intensity Therapy workers)

have been commissioned by SHA IAPT teams each year, using a top-slice of the region’s IAPT funding. In the second and third years, the funding administered centrally and regionally in the previous year has gone into PCT baselines. For 2011/12, the full £173 million announced in 2007 is in PCT baselines.

2.2 Broadening the scope of IAPT

The Coalition Government now wants to go further: to complete the roll-out and expand access to psychological therapies to children and young people, older people, and those with long term physical or mental health conditions. It has also committed the NHS to ensuring that people can have a choice of therapy from all those approved by NICE for treating depression.

The commitment to choice based on updated NICE Guidelines for the treatment of Depression published in October 2009, (see Annex 2) prompted the IAPT Programme to widen the range of therapies on offer within IAPT services.

Four additional psychological therapies for depression have been set out in the NICE-approved guidelines to broaden the range of therapies available to
patients at step 3. They are in addition to CBT and likely to be delivered by therapists beyond the core workforce developed to date. They are:-

- Brief Dynamic Psychotherapy, developed as Dynamic Interpersonal Therapy for Depression (DIT)
- Counselling for Depression
- Interpersonal Psychotherapy for Depression (IPT)
- Behavioural Couple Therapy, developed as Couple Therapy for Depression

2.3 Service Commissioning

The existing guidance relating to IAPT service commissioning is being revised and is available on the IAPT website (www.iapt.nhs.uk). As the IAPT approach to date has been a joint one between services and education providers, it is important that the guidance in this paper is read alongside the document published on 4 November 2010: Commissioning Talking Therapies for 2011/12 available at:- http://www.iapt.nhs.uk/wp-content/uploads/commissioning_talking_therapies_briefing_note_final_v2-0.pdf

Commissioners will take into consideration guidance related to the QIPP and Choice agenda.

Commissioners will be seeking to improve the efficiency of existing services, for instance by reducing variation in quality, accessibility and cost of services.

Commissioners should recognise that the nature of their workforce (make-up, skills and competency) will contribute to the extent to which they achieve adequate patient throughput, quality clinical outcomes and patient choice of therapies. It is important for longer-term sustainability that they consider the role of education and training within their service configuration.

2.4 IAPT 2011/12

The Government has committed the NHS to complete the IAPT programme to ensure services are available across the NHS by spring 2015 (see NHS Operating Framework for the NHS in England 2011/12, para 4.40).

To fund this, the Health settlement for the Spending Review period 2011/12-2014/15, announced on 20 October 2010 included ‘expanding access to psychological therapies’. Subsequently, the publication of the cross-Government mental health strategy No health without mental health on 2 February 2011 included confirmation that around £400 million would be available to the NHS over the period to April 2015 to achieve this aim.

This investment is calculated to save the NHS £272 million over the next six years, with overall public sector savings rising to over £700m during the same period. PCT and GP Commissioning Consortia will be encouraged to prioritise investing in these services to achieve local quality and cost improvements as part of the QIPP programme. The full Regulatory Impact Assessment and other supporting information is available on the DH website: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123997.pdf
Talking Therapies: a four-year plan of action, published in conjunction with No health without mental health, makes clear that the aim is to complete the nationwide roll-out of IAPT training and services by 2013/14 and maintain the position in 2014/15. In the context of changes to the NHS architecture, the funding flows cannot be the same as in the first phase of implementation, although the NHS will be accountable through delivering the ambitions set out nationally.

Some SHAs are looking to prioritise funding to enable the commissioning of training places and the continued co-ordination of their regional roll-out of IAPT. In view of the forthcoming changes to the NHS architecture, SHAs will want to plan this year for an effective transition to new arrangements for commissioning the 2012/13 training, following their own closure, and for commissioning the 2013/14 training, following the closure of PCTs and the birth of GP Consortia.

2.5 Funding flow for training 2011 and beyond
As SHAs prepare to close at the end of March 2012, the best available way to support the training programme is through MPET because this allows the funding to be concentrated on the trainees appointed in the specific PCT areas which establish and consolidate IAPT services in each of the three years involved.

The Service Level Agreement (SLA) between the Department of Health and the Strategic Health Authorities 2011/12 sets out the Department of Health’s main expectations for the use of the MPET funding.

2.6 Equity and Excellence
The vision set out in the white paper Equity and Excellence: Liberating the NHS can only be achieved if healthcare providers employ staff with the skill mix appropriate to deliver a high quality service to patients in every circumstance.

Liberating the NHS: Developing the Healthcare Workforce (in consultation) emphasises the opportunity to fundamentally reshape workforce education and training, the importance of high quality education and training that supports safe, high quality care and greater flexibility.

The role of the professional bodies e.g. BPS, BABCP, BACP, UKCP, BSCPC, BPC and IPTUK will be important in terms of IAPT accreditation standards going forward and there is agreement with them to do so. It is expected there will be continuing liaison in 2011/12 onwards between IAPT and professional bodies.

The involvement of GPs as commissioners and providers in PCT clusters and consortia are essential in determining the needs led, bottom up, commissioning of services and education and training, supported by the proposed Skills Networks.

It is expected that the Centre for Workforce Intelligence and the proposed Health Education England will both play an increasingly significant role in supporting the work required to develop the psychological healthcare workforce. SHAs will play a central role in leading the transition to the new system up to April 2012.
3 CAPACITY PLANNING – THE NUMBERS AND TYPES OF TRAINING

Numbers of trainees are for local determination based on local need and the advice and guidance from the central team, which is in place to offer support to regions as they address all the issues in the programme – including work on capacity planning. Given that IAPT constitutes a new workforce, services may require additional support to help them determine the demand for these new practitioners within their locality. The numbers given below in Annex 1 are for England as a whole. It is assumed that SHA allocations will be on a per capita basis.

3.1 Delivering NICE recommended therapies
The training numbers approved by IAPT are to meet the requirements for staffing NICE-concordant stepped care services for depression and anxiety. The numbers of trainees needed are based on SHA estimates for each PCT meeting 15% of their local population need for treatment. The types of training are designed around the competences staff will require to deliver NICE-recommended therapies.

3.2 Cognitive Behavioural Therapy (CBT) workers
For full coverage across the NHS, the IAPT programme requires a total of 6,000 new IAPT High Intensity and PWP workers. By March 2011, 3,600 will have been trained. The shortfall of 2,400 can be met by training a further 800 in 2011/12 and in the subsequent two years.

In order to ensure the training positions are new posts where possible, and can be advertised in open competition, MPET should cover both tuition fees and personal support (salary) during the training year. However, it is recognised that SHAs may want to explore a range of options for the personal support element (for example bursaries for PWPs) to build local capacity while ensuring that learning outcomes and quality standards are achieved.

3.3 Delivering Stepped Care
To offer a stepped care service model that can meet the range of presenting problems, it is recommended that the CBT element of IAPT services teams should be configured with 60% high intensity workers and 40% low intensity workers (PWPs). This total capacity should be supplemented by workers providing the other NICE-approved modalities, which it is recommended should account for at least 8-16% of the IAPT service team’s capacity.

3.4 Training in other NICE–approved therapies for Depression
NICE recommends interpersonal psychotherapy (IPT), couple therapy, counselling and brief dynamic psychotherapy as additional high intensity interventions for depression. The Government has committed to making these treatments available in all IAPT services as part of its patient choice agenda.

This requires each SHA to facilitate access to training programmes in each of these additional recommended treatments in 2011/12, and for the subsequent two years.

The exact number of therapists who are trained in 2012/13 will depend on the capacity of local providers to identify existing suitably qualified staff to meet the competence requirements of the CPD training and provide the necessary supervision.
3.5 **Choice**
Local commissioners will want to ensure providers have the flexibility to offer patient choice of NICE approved therapies on an equitable basis (i.e. reasonable waiting times). Based on current estimates of allocations at Step 3 within an IAPT service model, it is expected between 8 and 16% of patients should be able to access these treatments.

On this projection by 2014/15 a sufficient trained IAPT workforce with capacity to treat up to 144,000 patients in these therapies will need to be in place.

3.6 **Staff Turnover**
As with any other NHS workforce, there will be turnover of IAPT workers. SHAs will want to plan sufficient extra training capacity to train new recruits and possibly backfill these vacancies. They will also need to allow for student attrition from courses. It is recommended that an additional 10% of training places are commissioned to address this risk (as set out in the schedule at Annex 1).

3.7 **Supervisor training**
The success of the IAPT programme crucially depends on the availability of fully trained practitioners who are able to supervise trainees to deliver the expected performance benchmarks for recovery. Most SHAs provided supervisor training courses in 2010/11 and these need to continue for high-intensity CBT, PWP and the additional NICE recommended therapy trainees in 2011/12.

3.8 **Service Training Standards**
The IAPT training programme requires trainees to learn from observation while working in fully functioning IAPT services, as well as through workshops and other events provided by a Higher Education Institute.

Recommended ‘Quality assurance criteria for the learning experience that IAPT trainees receive in an IAPT service’ can be found on the IAPT website (http://www.iapt.nhs.uk/?=quality+assurance+criteria+for+the+learning+experience).

In order to ensure successful individual practitioner and course accreditation outcomes, it is essential that trainees conduct their supervised practice only in services that meet the above criteria, as judged jointly by the education providers and education commissioners.

IAPT service providers should work in partnership with education and training providers to ensure all service training standards are met.

4. **COMMISSIONING TRAINING COURSES**

4.1 **Accredited courses**
SHAs will need to commission courses that provide the required training. Quality is of paramount importance to ensure that the workforce is fit for purpose to deliver NICE recommended interventions. The essential quality standards to achieve this are outlined below:
(a) Training must be delivered by IAPT approved accredited courses for PWP, High Intensity CBT, Counselling for Depression, Interpersonal Psychotherapy for Depression (IPT), Couple Therapy for Depression, Brief Dynamic Interpersonal Therapy for Depression (DIT) and IAPT supervision courses.

(b) Practitioners should be accredited for all the above.

(c) Training must meet the Quality Assurance Criteria for the learning experience of IAPT Trainees (www.iapt.nhs.uk)

In the case of High Intensity CBT and PWP trainees, the courses should follow the published National Curricula based on published competencies (available at http://www.iapt.nhs.uk) and be accredited as an IAPT approved course currently or by the time the first cohort of trainees graduate. The full time training courses last one academic year but different areas have chosen to begin their training at different times (e.g. October, November, January, April to suit their local needs.)

Currently, PWP courses are 45 days in total. PWP Trainees spend one day a week in class, one further day a week working on learning directed by education providers and three days delivering supervised services to patients, leading to a post-graduate certificate (with an undergraduate option). High Intensity Therapist trainees spend two days a week in class and three days a week delivering supervised services to patients, leading to a post-graduate diploma. The remainder of the first calendar year of their employment with the IAPT service is regarded as consolidating the training in practice and the salaries of trainees have therefore been funded for this period as part of their training.

Courses for staff to deliver the additional NICE recommended therapies should be based on the published competencies for the use of these treatments in depression and should follow the relevant (soon to be published) National Curricula, together with supervised practice. These courses will also then need to become accredited as IAPT approved.

A list of accredited High Intensity and PWP Courses are available on the British Association for Behaviour Cognitive Psychotherapies (BABCP) websites and British Psychological Society (BPS) respectively.

Liberating the NHS: Developing the Healthcare Workforce, Section 8 (in consultation) outlines how workforce development may change, whilst maintaining high quality services for patients.

SHAs should consider flexibilities for training placements and employment, whilst ensuring that quality is not compromised. See 5.3 below.

Examples of flexibilities have already started to be developed in areas throughout England. The central IAPT team is committed to working to support workforce colleagues in exploring these approaches and disseminating best practice as it becomes available.

Annex 1 provides the IAPT National Training Costs and Places Summary Table 2011/12.

4.2 Agenda for Change (AfC)
It is for the NHS to determine the appropriate salary scales for this workforce. However, as a guideline, PWPs are usually appointed at AfC band 4 during
training, while High intensity trainees are appointed at AfC band 6 or 7, depending on their pre-existing skills and ability to take on moderately complex cases from the start.

The banding of the staff groups that deliver the other NICE approved therapies will vary, as these are drawn from the existing local workforce.

5. SERVICE AND TRAINING MODEL

5.1 Existing model
The current model of earn and learn relies on new posts for new and expanding services, national advertisements, joint selection and similar AfC banding. Typically a trainee is employed into a post that becomes substantive on successful completion of that training.

It is clear that there will be challenges for PCTs to commission new posts and support expanded integrated IAPT services at this time in order to deliver the commitment within the Operating Framework.

Although the existing model is the preferred model, it is important to address the risks and consider options for how they may be addressed.

5.2 Risks
There are a range of risks in delivering the elements of the training specification within the MPET allocation. It is proposed that advice and support in addressing them will be available from the central IAPT team.

5.3 Options and possibilities for the future
The future is likely to be particularly challenging due to changing structures and limited timescales. As long as the quality standards referred to in 4.1 are adhered to, options that could be considered to ensure sustainability and development of education and training include:

(i) Analysing outcomes of existing IAPT services and prioritising resources that reflect maximum value for money to encourage prioritisation of IAPT development. The full Regulatory Impact Assessment and other supporting information is available on the DH website:

(ii) Develop flexible training options to encourage HEIs to:-

- Develop part-time training for PWP and High Intensity workers
- Make existing IAPT modules accessible for different staff groups, for example PWP competency modules for existing qualified practitioners supervising PWPs; and for Modern Matrons/specialist nurses/ practice nurses supporting Collaborative Care.
- Develop new specialist modules for older people, children and young people, and for those with long term physical and mental health conditions once these have been agreed by the relevant expert groups.
(iii) Commissioning some training places without guarantee of job post qualification

(iv) Developing different forms of student support options related to different roles, trainings and local preferences to build capacity locally. Including bursaries; part-time employment opportunities; and exploring the potential of a ‘host employer’ model to generate employer flexibilities.

(v) Enhancing skills of existing staff, particularly for non-CBT trainees, to deliver the NICE recommended interventions including counsellors, psychotherapists and primary care workers, potentially in all five step-three interventions.

(vi) Recognising that, due to service transformation outside IAPT services, some newly qualified and experienced staff may consider different career options by undertaking IAPT training, potentially moving into IAPT roles or enhancing existing services ensuring that IAPT standards are adhered to.

(vii) Using a combination of training posts: e.g. Substantive appointments with a guarantee of employment in the same IAPT service after training; and training posts where the in-service training occurs in an IAPT service that provides an in-service placement, without a guarantee of appointment on qualification.

(viii) Integrating continuation of the current training, wherever possible, with the new service developments required by the Coalition, extending access to new populations, including older people, people with medically unexplained symptoms, long term conditions, severe mental illness and children and young people with mental health needs.

6. CONCLUSIONS

6.1 Where possible, education and training commissioners are encouraged to replicate the current and original models of training and education commissioning to reach the IAPT target number for training places and service delivery.

6.2 Where any significant changes to the existing model of training and education are being explored, it must be possible to demonstrate the overarching principles of accreditation. Advice and support will be available from the national IAPT Team for the immediate future.

6.3 Education and training commissioners should continue contracts with a smaller number of training courses for PWP and High Intensity CBT education providers, ensuring accreditation is in place.

6.4 Highlight areas of service weakness and focus new investment in posts within PCTs and employers most likely to maximise IAPT service provision.

6.5 Develop the existing workforce by ensuring selection of high quality trainees and supervisors and developing contracts with high quality training providers.
6.6 Keep supervision as a key priority.

March 2011
Annex 1:
IAPT National Training Costs and Places Summary Table 2011/12

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### Annex 2: NICE Indicated Treatments for Depression and Anxiety Disorders

#### Step 1: Primary Care/ IAPT Service
- Recognition of problem
- Moderate to Severe Depression with a chronic physical health problem

**Assessment/Referral/Active Monitoring**, includes careful monitoring of symptoms, psychoeducation about the disorder and sleep hygiene advice.

Collaborative care (consider in light of specialist assessment if depression has not responded to initial course of high intensity intervention and/or medication)

#### Step 2: Low Intensity Interventions
- Panic Disorder
- Post Traumatic Stress Disorder (PTSD)
- Generalised Anxiety Disorder (GAD)
- Obsessive Compulsive Disorder (OCD)
- Social Phobia

**Depression**

- CBT

**Pan disorder**

- CBT

**PTSD**

- CBT

**GAD**

- CBT

**OCD**

- CBT

**Social Phobia**

- CBT

#### Step 3: High Intensity Interventions
- Depression: moderate to severe
- Depression: mild to moderate for individuals with an inadequate response to initial interventions at Step 2

**Cognitive Behavioural Therapy (CBT) or Interpersonal Therapy (IPT), each with medication**

**CBT or IPT**

**Behavioural Activation (BA), a variant of CBT**

**Behavioural Couples Therapy (if the patient has a partner, the relationship is considered to be contributing to the maintenance of the depression, and both parties wish to work together in therapy)**

**Guided Self-Help based on CBT, Computerized CBT, Behavioural Activation, Structured Physical Activity**

**Self-Help based on CBT, Computerized CBT**

**None**

**Guided Self-Help based on CBT**

**None**

#### Notes:
1. NICE Guidance on treatment of "Depression" and "Depression in people with a chronic physical health problem." The two guidelines are very similar. However, it should be noted that the "depression with a physical health problem" guideline does not recommend IPT, behavioural activation, counselling or brief dynamic therapy as high intensity interventions.
2. Although the recent update of the NICE Guidance for Depression recommends Behavioural Activation for the treatment of mild to moderate depression, it notes that the evidence base is not as strong as for CBT or IPT.
3. PTSD: NICE had not recommended low intensity treatments.
4. Social Phobia: NICE has not yet issued guidance on the treatment of social phobia. However, there is a substantial body of evidence supporting the effectiveness of high intensity CBT. Low intensity versions of CBT are being developed by several groups around the world and are likely to play a useful role in the future. At least one trial has also demonstrated that IPT is effective.
Annex 3

Reference Documents


Equity and Excellence: Liberating the NHS. Department of Health. 12 July 2010.

No health without mental health: a cross Government mental health outcomes strategy for people of all ages. HM Government. 2 Feb 2011.


Liberating the NHS: Developing the healthcare workforce. A consultation document. Published by the Department of Health. 20 December 2010. (Consultation closes 31 March 2011)

Annex 4

Glossary

Professional bodies identified:
BABCP  British Association for Behavioural and Cognitive Psychotherapies
BACP  British Association for Counselling and Psychotherapy
BPC  British Psychoanalytical Council
BPS  British Psychological Society
BSCPC  British Society of Couple Psychotherapists and Counsellors
IPTUK  UK Interpersonal Psychotherapy – Special Interest Group
UKCP  United Kingdom Council for Psychotherapy