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Improving Access to Psychological Therapies

NHS

Improving Access to Psychological Therapies

Guidance for Commissioning IAPT Training 2012/13

Revised July 2012

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EXECUTIVE SUMMARY

On 27 March 2012, the Health and Social Care Bill received Royal Assent and became an Act of Parliament. As the reorganisation of the NHS unfolds, new arrangements are being developed to continue commissioning all the IAPT training needed and to take account of future changes. This document is a reflection of the health and care system as at the time of publication. There will be continuing capacity in 2012/13 to support the roll-out of IAPT regionally and nationally.

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.

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 includes around £433 million for psychological therapies over the period to April 2015. The NHS has already been notified of SHA allocations for 2012-13, which included funding for increasing access to talking therapies. Funding will continue to increase to enable SHAs to realise this commitment, on top of the annual allocation of £173m from the first phase of the programme, which will continue. 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 for funding the expansion of an IAPT workforce. Included within the funding arrangements is the commitment that the education, training and some salary costs to support IAPT therapists-in-training will be met from within the MPET budget.

This commitment involves regional commissioning of Cognitive Behavioural Therapy High Intensity, Psychological Wellbeing Practitioners (PWPs) and 4 Additional High Intensity [Counselling for Depression (CfD), Interpersonal Therapy (IPT), Dynamic Interpersonal Therapy (DIT) and Couple Therapy for Depression (CofD)] training places to a national total of approximately 800 per year for three years. Each SHA has been notified of their regional commitment and is expected to meet a proportion of the national expectation. The total 2012-13 MPET allocation for IAPT totals £32.597m.

CBT High Intensity and PWP training, 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, to provide patient choice of therapy, regional commissioning of training for approximately 400 already-qualified therapists per annum in four modalities is expected; CfD, IPT, DIT and CofD. These trainings are delivered in a 5-day format followed by supervised practice, treating clients with mild-to-moderate depression.

Total numbers of trainees and qualified staff in each modality is for local determination. Where there has been insufficient recruitment of trainees to expand service provision and meet a minimum 15 per cent prevalence by 2014-15, SHAs or SHA Clusters will need to factor this into commissioning intentions and address any shortfall. Likewise, where there are inequitable waiting times for access to interventions in local IAPT care pathways, strategic workforce planning should be adjusted to respond by training additional capacity.

Alongside completing the roll-out of IAPT services, the 2010 Spending Review settlement allowed 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 health conditions or medically unexplained symptoms, people with severe mental illness, and older people.

1. PURPOSE AND STRUCTURE

1.1. This document is a guide for education and training commissioners of the Improving Access to Psychological Therapies (IAPT) workforce using the Multi Professional Education and Training (MPET) funding allocation.

1.2. The key workforce aims of the programme are to:
- Complete the nationwide roll-out of the IAPT training programme to achieve 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[1] and elsewhere.

1.4. This document should be read in conjunction with the 'MPET Service Level Agreement 2012/13', 'Financial Information Management System (FIMS) Guidance' and other relevant documents, for example, regional investment plans.

1.5. A summary of the emerging projected number of training places SHA Training Investment plans and the funding arrangements MPET will cover in 2012/13 appears at Annex 1.

1.6. This 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.

2. INTRODUCTION AND OVERVIEW

Background to the IAPT programme

2.1 The Improving Access to Psychological Therapies programme began in October 2008 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.

2.2 The investment was the first phase of a six-year implementation phase, establishing training courses, services and new IT and workforce infrastructures around the country. As of December 2011,
- IAPT services are meeting over 8.44 per cent of the expected demand to provide psychological therapies and meet 15 per cent prevalence of depression and anxiety disorders in local communities.
- Over 3,200 new psychological therapy workers have successfully completed training
- Over 985,000 people have received evidence-based, NICE-approved psychological therapies for depression and anxiety disorders with over 596,000 completing treatment
- Over 213,000 people moved to recovery
- Over 39,000 of those treated came off sick pay and benefits and/or started or returned to work.

[1] http://www.iapt.nhs.uk

2.3 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 conjunction with their SHA Workforce colleagues for the last four 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, which responds to the full range of mild-moderate, complex and severe psychological needs.

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2.4 Training courses have been commissioned by SHA IAPT teams each year for:

- CBT High Intensity Therapy workers
- Psychological Wellbeing Practitioners (formerly known as Low Intensity Therapy workers)
- From 2010, High Intensity CPD for qualified therapists delivering 4 additional evidence based therapies (Counselling for Depression (CfD), Interpersonal Therapy (IPT), Brief Dynamic Interpersonal Therapy (DIT) and Couple Therapy for Depression (CofD)

Broadening the scope of IAPT

2.5 The Coalition Government agreed further Government investment in 2012/13 taking IAPT funding to £288m in this financial year to complete the rollout and extend 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 have a choice of therapy from all those approved by NICE for treating depression.

Service Commissioning

2.6 The NHS Operating Framework has identified IAPT as a priority in 2012/13.

> ‘For 2012-13 particular focus is needed on improving:
>
> access to psychological therapies as part of the commitment to full roll-out by 2014/15 so that services remain on track to meet at least 15 per cent of disorder prevalence, with a recovery rate of at least 50 per cent in fully established services. During 2012/13 this will mean increased access for black and minority ethnic groups and older people and increased availability of psychological therapies for people with severe mental illness and long term physical health problems[2];

2.7 Commissioners will be seeking to improve the efficiency of existing services, for instance by reducing variation in quality, accessibility and cost of services. Commissioners will also take into consideration guidance related to the QIPP and Choice agenda. It is important for longer-term sustainability that commissioners consider the role of education and training within their service configuration.

2.8 Quality is of paramount importance to ensure that the workforce is fit for purpose to deliver NICE recommended interventions. The essential quality assurance criteria designed to help achieve this are stated in the guidance document 'Quality Assurance Criteria for IAPT trainees' available from the IAPT website3*"

2.9 Commissioners will wish to plan the nature and configuration of their workforce (capacity, make-up, skills, size and competency) in order to continue to build towards meeting the local prevalence of depression and anxiety disorders, achieving adequate

[2] ‘The Operating Framework for the NHS in England 2012/13’
[3] http://www.iapt.nhs.uk/silo/files/quality-assurance-criteria-for-iapt-trainees.pdf

patient throughput and waiting times, quality benchmarks for clinical outcomes, patient choice of therapies, and high satisfaction ratings.

2.10 Commissioners should be mindful of the need for IAPT services to have a culturally competent workforce that can meet the mental health needs of the whole community and particularly groups within the population who have high prevalence rates of depression and anxiety. The IAPT programme has produced Positive Practice Guides that provide useful information for services to assist in engaging and providing services for:

- Black and Minority Ethnic communities
- Older People
- Perinatal care
- Offenders
- Long Terms Condition
- Medically Unexplained Symptoms
- Veterans
- Learning Disability
- Working with people who use drugs and alcohol, co-produced with the National Treatment Agency and DrugScope

In addition, the IAPT programme has worked with the British Society for Mental Health for the Deaf and Liverpool John Moores University to develop a PWP training course to train users of British Sign Language (BSL) to provide low intensity interventions within the Deaf community in BSL.

2.11 Commissioning of top up training for the existing qualified IAPT staff to improve access to psychological therapies for Older People should be undertaken from September 2012. An indicative two-day curriculum, based on agreed competences for working with Older People, will be available to underpin training.

2.12 Commissioners should be aware that these training opportunities should be made available to all staff including those who are employed in the voluntary and private sectors. In addition, if course viability is in question due to low numbers commissioners could consider how to make training places available to independent therapists and other NHS staff working in other areas of the NHS, who may wish to fund themselves to undertake such training but are not salaried to do so.

Education and Training Structure from April 2012

2.13 The *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 end of the spending review period in March 2015.

2.14 SHAs or SHA Clusters will need 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 2013/14 training, following their own closure, and for commissioning the 2014/15 training, following the closure of PCTs and the beginning of Clinical Commissioning Groups.

2.15 The Service Level Agreement (SLA) between the Department of Health and the Strategic Health Authorities 2012/13 sets out the Department of Health's main expectations for the use of the MPET funding.

2.16 From 1 April 2013, the NHS system is changing and therefore the way in which the workforce is educated and trained will change. Two new organisations will form the new education and training system, Health Education England (HEE) and Local Education and Training Boards (LETBs)

2.17 Health Education England (HEE) will provide national leadership and oversight on strategic planning and development of the health and public health workforce. HEE will be responsible for:

- Allocating education and training resources
- Promoting high quality education and training that is responsive to the changing needs of patients and local communities.

2.18 The LETBs will be the vehicle for providers and professionals to work with HEE to improve the quality of education and training outcomes so that they meet the needs of service providers, patients and the public. Through HEE, health providers will have strong input into the development of national strategies and priorities so education and training can adapt quickly to new ways of working and new models of service. LETBs may also take on specific leadership roles for particular professional groups, such as the smaller professions and commissioning specialist skills[4].

3. CAPACITY PLANNING – NUMBERS AND TYPES OF TRAINING

3.1. Trainee numbers are for local determination and based on local need sufficient to meet access needs and at least 15 per cent prevalence. The advice and guidance is available from the central team, to offer support to regions.

Delivering Stepped Care

3.2. For IAPT to offer a stepped care service model that can meet the range of presenting problems, it is recommended that IAPT teams should be configured with 60 per cent high intensity capacity and 40 per cent low intensity capacity. The 60:40 split is a central model assumption. Service models at local level have ratios varying between 70:30 and 50:50, all of which are good practice and vary in accordance with local skill mix.

3.3. Workers providing other NICE-approved modalities should be able to meet patient preference based on informed choice of the options for the patient's presenting issues, and within equitable waiting times for the service as a whole. Building capacity for each modality within total IAPT staff numbers is therefore for local determination based on local access needs and patterns of patient preference. Annex 2 shows the recommended Stepped Care Pathway for IAPT services and a choice of therapy algorithm is available on the IAPT web site.

Achieving Full Coverage

3.4. For full coverage across the NHS, the IAPT programme requires a total recruitment of 6,000 IAPT CBT High Intensity and PWP workers by 2014/15. With around 3,600 staff

[4] 'Liberating the NHS: Developing the Healthcare Workforce From Design to delivery'

already recruited in the first phase of the programme, this equates to the recruitment and retention of 800 CBT therapists per year for each of the next 3 years.

3.5. In order to ensure the training positions enable service growth, 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.

3.6. Completing the roll-out of IAPT requires the continued recruitment and retention of trainees to ensure the expansion of services up to the academic year 2013-14. SHAs continued investment in salary costs and increasing trainee numbers support the delivery of objectives in the Talking Therapies Four Year Plan and the cross-government strategy *'No Health without Mental Health'*.

Training in non-CBT therapies for people with depression

3.7. In response to the updated NICE Guidance for the treatment of depression published in 2009, four additional High Intensity psychological therapy trainings for depression were developed by the IAPT programme to broaden the range of therapies available to patients at step 3.

3.8. They are designed for qualified therapists who already have experience delivering therapy in these modalities and are likely to be delivered by therapists beyond the core IAPT workforce developed to date:-

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

3.9. This commitment in the second phase of workforce investment to achieve rapid diffusion of therapist and supervision capacity to deliver patient choice requires each SHA to facilitate access to training programmes in each of these additional recommended treatments in 2012/13, and for the subsequent two financial years.

Staff Turnover

3.10. As with any other NHS workforce, there will be turnover of IAPT workers. SHAs will want to plan sufficient extra training capacity to train for replacement therapist and possibly backfill these vacancies. SHAs 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), although local recruitment and retention may vary, requiring greater or fewer numbers of replacement places.

Supervisor training

3.11. 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 2011/12 and these need to continue for high-intensity CBT, PWP and the additional high intensity therapy trainees, in 2012/13.

4. COMMISSIONING TRAINING COURSES

Accredited Courses

4.1. Commissioners should ensure that courses are appropriately accredited. IAPT guidance on accreditation has been published on the website[5]. Individual practitioners should be accredited for each modality in which they have qualified. The essential quality standards to achieve accreditation 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 are accredited in the appropriate modality.

4.2. In the case of High Intensity CBT and PWP trainees, the courses should follow the published National Curriculae based on published competencies[6] 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.)

4.3. 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 CBT 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.

4.4. Courses for staff to deliver the additional High Intensity therapies should be based on the published competencies on the IAPT website, for the use of these treatments in depression and should follow the relevant National Curriculae, together with completion of supervised practice.

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

4.6. *Liberating the NHS: Developing the Healthcare Workforce*[7], Section 6, outlines how workforce development may change, whilst maintaining high quality services for patients.

4.7. SHAs should consider flexibilities for training placements and employment, whilst ensuring that quality is not compromised (see section 5 below).

4.8. Examples of flexibilities in workforce employment and development already exist in some areas. The central IAPT team is committed to working to support workforce

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[5] http://www.iapt.nhs.uk/workforce/accreditation
[6] http://www.iapt.nhs.uk/workforce
[7] 'Liberating the NHS: Developing the Healthcare Workforce From Design to delivery'

colleagues in exploring these approaches and disseminating best practice as it becomes available.

4.9. Annex 1 provides a table showing a summary of emerging IAPT National Training Costs and Places commissioned by SHAs in 2012/13.

5. SERVICE TRAINING MODEL

Existing Model

5.1. The current IAPT model of 'earn and learn' relies on expansion posts for new and expanding services, national advertisements, joint selection and AfC banding. Within this model, a trainee is employed into a post that becomes substantive on successful completion of that training. This is the preferred model for recruiting, training and employing trainees.

5.2. In addition, as IAPT services continue to grow and mature there is a need to provide 'fees-only training' for trainees who are filling vacant posts within IAPT services. These trainees are referred to as replacement trainees.

5.3. It is essential that the SHA's commitment to additional training provision is implemented through an agreement between IAPT Regional Leads, SHA Workforce colleagues and local services. This means creating additional qualified posts, in order to achieve required workforce capacity and generating the necessary posts to employ newly qualified trainees. This equates to assessing and balancing workforce demand and supply in relation to service user needs, preference and access.

5.4. It is clear that there are challenges for PCTs in commissioning expansion posts and there is a need for expanded integrated IAPT services in order to deliver the commitment within the Operating Framework.

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

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

5.7. Commissioners will need to pay particular attention to IAPT services facing contract renewal in order to ensure that these services can continue to employ trainees and offer training placements. This will ensure that the SHA and national programme are able to meet final training numbers.

Any Qualified Provider

5.8. Commissioners have a choice of any qualified provider and will need to ensure that providers are able to offer the same high quality standard training and continue to commission at required levels to sustain the delivery of IAPT services, which meets 15 per cent prevalence.

Variations to the IAPT model for recruiting and training trainees

5.9. In 2011-12, some SHAs adopted variations to this model. In those regions, there was an insufficient number of trainees recruited using the existing IAPT model. To make-up the shortfall, full salary costs and fees for trainees were paid on a fixed term one-year contract to cover the period of training. The IAPT regional teams worked with services

to agree ongoing employment contracts for these trainees in IAPT services during the year of training resulting in newly qualified therapists receiving employment contracts in IAPT services.

5.10. There is risk in varying the IAPT model. A one-year fixed term trainee contract offers a short-term solution, which delivers the required number of trainees. However, unless employment opportunities in IAPT services are found for these trainees this will not lead to the increases in workforce size and capacity required to meet the 15% prevalence rate over the period of the Talking Therapies Four Year Plan of Action. Newly qualified staff, who are not offered employment contracts within the service where they received their training, could be offered employment with providers who are entering the market.

5.11. As stated earlier, SHAs have offered fees-paid training to IAPT services to replace staff who have left IAPT services. Some services used this as an opportunity to second staff into a trainee role from non–IAPT providers including specialist physical health teams, primary care teams. It is important to ensure that these trainees are appropriately supervised in their practice. This may require working across services to provide appropriate staff within clinical services that can support the learning and supervision requirements of these IAPT trainees.

5.12. NHS North West is developing a Workforce Tracker to track the movement of IAPT trainees as they move into services. This tracker or a similar process should be used to support IAPT regional teams to track IAPT trainees and staff to assist in ensuring that trainees find employment and to assist commissioners and services to quantify the number of replacements required by IAPT services

6. CONCLUSION

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 to contract training courses for PWP and High Intensity CBT education providers, and the additional High Intensity modality trainings, ensuring accreditation is in place.

6.4. Education and training commissioners should address shortfalls in the number of 2011/12 CBT therapists by increasing recruitment in 2012/13. This will entail highlighting areas of service weakness to focus new investment in expansion and replacement posts within PCTs.

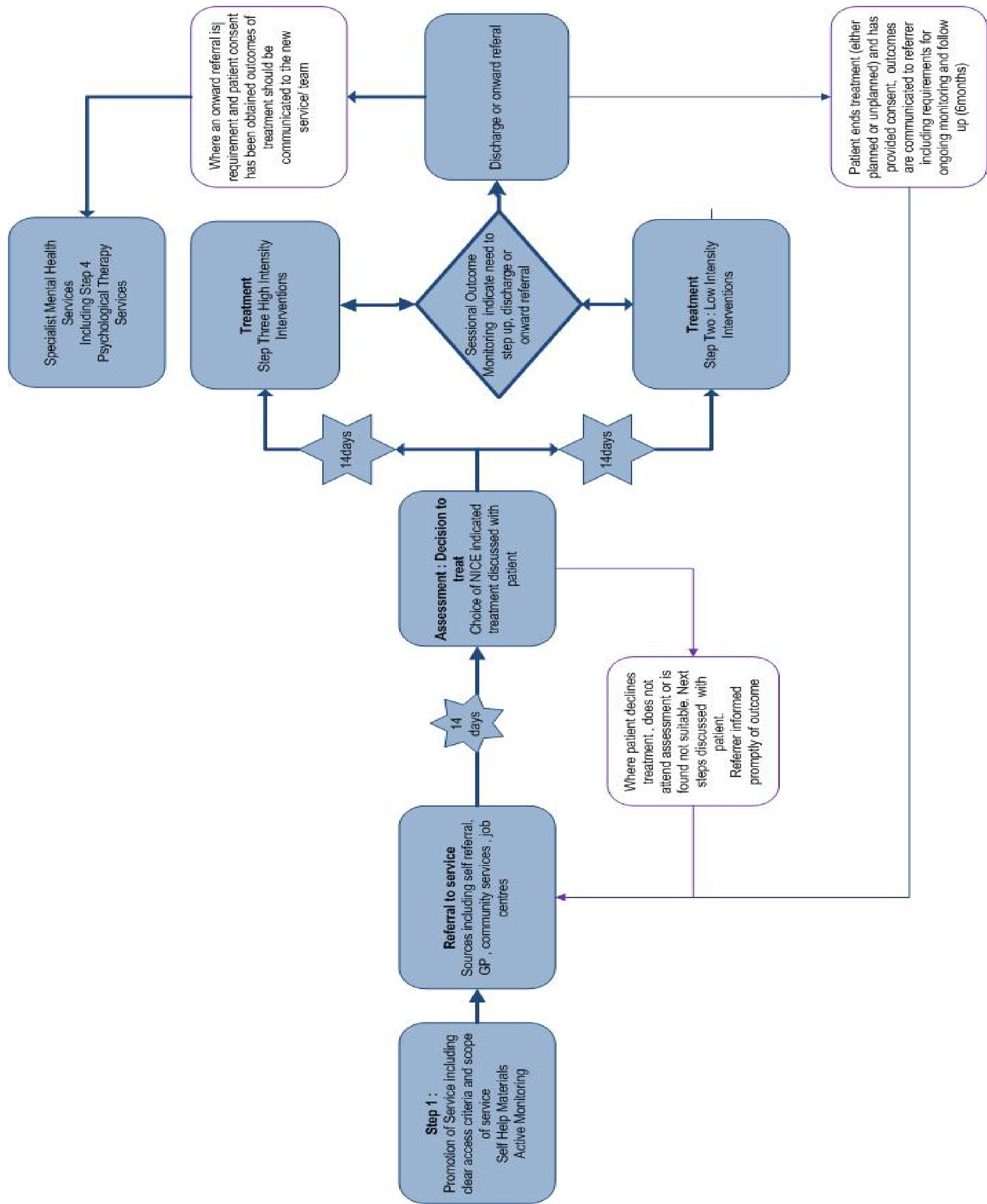
6.5. Education and training commissioners should develop the existing workforce by ensuring selection of high quality trainees and supervisors and developing contracts with high quality training providers.

6.6. Keep supervision as a key priority.

Annex 1: IAPT National Training Costs 2012/13 (Based on SHA Training Investment Plans)

Region	2011-12 Activity	Salary Support	Regional Investment	2012-13 Commissioning Intentions
East of England	• 150 low intensity-training programmes • Development of research projects looking at care pathways for patients with LTCs/MUS/Dementia/ Severe Mental Illness presenting with anxiety/depression • A number of regional services successful in DoH funding to develop services for people with Long Term Conditions		£0.522m	
East Midlands		£0.5m	£6.1m	
London		£0.384	£4.8m	
North East				26 HIT 16 PWP
North West				Commissioning plans in place for further HIT and PWP trainees, supervision training across all modalities and non-CBT therapies.
South East Coast			£2.789m	
South Central			£14.4m	
South West			£2.1m	
West Midlands	80 Commissions			80
Yorkshire and Humber			£4M	

Annex 2: Recommended Stepped Care Pathway for IAPT services



Annex 3: NICE indicated Treatments for Depression and Anxiety Disorders*

Focus of intervention	Nature of intervention
Step 4: **Depression:** severe and complex depression; risk to life; severe self-neglect **Generalised anxiety disorder:** complex treatment – refractory GAD and very marked functional impairment, such as self-neglect or a high risk of self-harm **Panic disorder, OCD and PTSD:** severe disorder with complex comorbidities, or people who have not responded to treatment at steps 1–3 (see note 1 below).	**Depression:** Highly specialist treatment, such as medication, high intensity psychological interventions, combined treatments, multiprofessional and inpatient care, crisis services, electroconvulsive therapy **Generalised anxiety disorder:** Highly specialist treatment, such as complex drug and/or psychological treatment regimens; input from multi-agency teams, crisis services, day hospitals or inpatient care **Panic disorder, OCD and PTSD:** see note 1 below.
Step 3: **Depression:** persistent subthreshold depressive symptoms or mild to moderate depression that has not responded to a low-intensity intervention; initial presentation of moderate or severe depression **Generalised anxiety disorder:** with marked functional impairment or that has not responded to a low-intensity intervention; **Panic disorder:** moderate to severe **OCD:** moderate or severe functional impairment **PTSD:** moderate or severe functional impairment.	**Depression:** CBT, IPT, behavioural activation, behavioural couples therapy, counselling*, short-term psychodynamic psychotherapy*, antidepressants, combined interventions, collaborative care**, self-help groups. **Generalised anxiety disorder:** CBT, applied relaxation, drug treatment, combined interventions, self-help groups. **Panic disorder:** CBT, antidepressants, self-help groups. **OCD:** CBT (including ERP), antidepressants, combined interventions and case management, self-help groups. **PTSD:** Trauma-focused CBT, EMDR, drug treatment. **All disorders:** Support groups, befriending, rehabilitation programmes, educational and employment support services; referral for further assessment and interventions.
Step 2: **Depression:** Persistent subthreshold depressive symptoms or mild to moderate depression **Generalised anxiety disorder** **Panic disorder:** mild to moderate **OCD:** mild to moderate **PTSD:** mild to moderate.	**Depression:** Individual facilitated self-help, computerised CBT, structured physical activity, group-based peer support (self-help) programmes**, non-directive counselling delivered at home***, antidepressants, self-help groups. **Generalised anxiety disorder and panic disorder:** Individual non-facilitated and facilitated self-help, psychoeducational groups, self-help groups. **OCD:** Individual or group CBT including ERP (typically provided within step 3 services; see note 2 below), self-help groups. **PTSD:** Trauma-focused CBT or EMDR (typically provided within step 3 services; see note 2 below). **All disorders:** Support groups, educational and employment support services; referral for further assessment and interventions.
Step 1: **All disorders:** known and suspected presentations of common mental health disorders.	**All disorders:** Identification, assessment, psychoeducation, active monitoring; referral for further assessment and interventions.

Note 1: The NICE clinical guidance on panic disorder (CG113) and OCD (CG31) uses different models of stepped care to the 4 step model used in the NICE clinical guidance on depression (CG90, CG91) and generalised anxiety disorder (CG113). The NICE clinical guideline on PTSD (CG26) does not use the stepped care model. People with panic disorder, OCD or PTSD that has not responded to treatment at steps 1–3, or who have severe disorders and complex comorbidities that prevent effective management at steps 1–3, should receive specialist services at step 4, according to individual need and clinical judgement. The principle interventions at step 4 are similar to those listed for depression and generalised anxiety disorder, with the exception that electroconvulsive therapy is not indicated.

Note 2: The NICE clinical guideline on OCD (CG31) recommends that people with mild to moderate OCD receive individual or group based CBT. The NICE clinical guideline on PTSD (CG26) recommends that people with mild to moderate PTSD receive trauma-focussed CBT or EMDR. These interventions may typically be commissioned from, and provided by, trained, high-intensity therapy staff in step 3 services.

* Discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression.

** For people with depression and a chronic physical health problem.

*** For women during pregnancy or the postnatal period.

Key: CBT - cognitive behavioural therapy; ERP - exposure and response prevention; EMDR - eye movement desensitisation and reprocessing; OCD - obsessive compulsive disorder; IPT - interpersonal therapy; PTSD - post traumatic stress disorder.

*2011 NICE Guidance 'Commissioning stepped care for people with common mental health disorders'