

Sent on Professor Louis Appleby's behalf.

Dear Antonia,

Thank you for your email of 1 December. I am very sorry for the delay in responding to you, but I do regard the points you raise as central to the development of the IAPT programme over the coming year.

The intention of the IAPT programme is not to replace the existing psychological therapists with a complete new workforce of CBT therapists. However, there is a substantial shortfall in the existing workforce - both in terms of absolute numbers and in those with competence in delivering CBT. As you know, CBT forms a core part of the NICE guidelines for the treatment of common mental health problems, but is commonly not practised across existing services.

Consequently, the IAPT training effort focuses on addressing these deficits and providing a spine of suitably qualified therapists to provide the core component of the new services. However, we are committed to enabling the NHS to deliver the full range of NICE-compliant therapies in the new IAPT services as they mature, so it will not be enough just to deliver this new cadre of CBT-trained therapists. The IAPT Implementation Plan (Feb 08) and the IAPT Commissioning Toolkit (April 08) provided guidance to PCTs that the new IAPT services should not replace existing services and encouraged them to work towards offering their patients a choice of NICE-compliant therapies by bringing existing therapists with the appropriate skills into the IAPT service.

This approach was confirmed in the Secretary of State's publication of the 'Statement of Intent' at the NSP Conference on 27 November, which stated that the Government is committed to:

'..work(ing) towards ensuring PCTs give all patients a choice of NICE-approved psychological interventions by:

- *Asking PCTs to offer appropriate choice of therapies as their IAPT services mature
- *Developing training for other NICE-approved interventions to support therapists' continuing professional development.'

We plan to issue guidance to PCTs to support the Statement of Intent in the Spring.

So, while we recognise the value of the existing psychological therapy workforce, there should be no doubt that we expect the implementation of IAPT to bring with it new requirements that all therapists should be supported to be able to demonstrate their competency to deliver

NICE-compliant interventions and the outcomes that they deliver in terms of improvements in health and wellbeing, based on the standard IAPT data set.

Turning to your specific questions, my comments are as follows:

1. Enabling the existing workforce of primary care therapists to be integrated into IAPT will require a commitment from commissioners (based on the guidelines we have provided) and the workforce itself to work together to identify how the new parts of the service can be effectively brought together with existing provision to more effectively meet the needs of the local population. I acknowledge that more guidance is needed to give clearer direction to commissioners in this area, but we have to rely on professional bodies such as yours and the BACP to encourage their members to engage with this opportunity positively.

2. We are developing training for the other NICE-approved interventions to support the CPD needs of the workforce and we have already made progress in developing training curricula for IPT. This work is being co-ordinated by the IAPT Education & Training Group, which includes representation from the New Savoy Partnership members. My suggestion is that you talk with Roslyn Hope (hopebookbinder@aol.com), chair of this group, and Jeremy Clarke (therapy@practice.demon.co.uk), NSP Chair, to discuss how best you may engage with this work.

I hope this response addresses your points satisfactorily and I thank you for your continued interest in supporting the successful implementation of the IAPT programme.

Yours sincerely,

Louis Appleby

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