

A drop in the ocean: couple therapy for depression in IAPT

Report from an investigation into the availability of couple therapy for depression in Improving Access to Psychological Therapies (IAPT) services

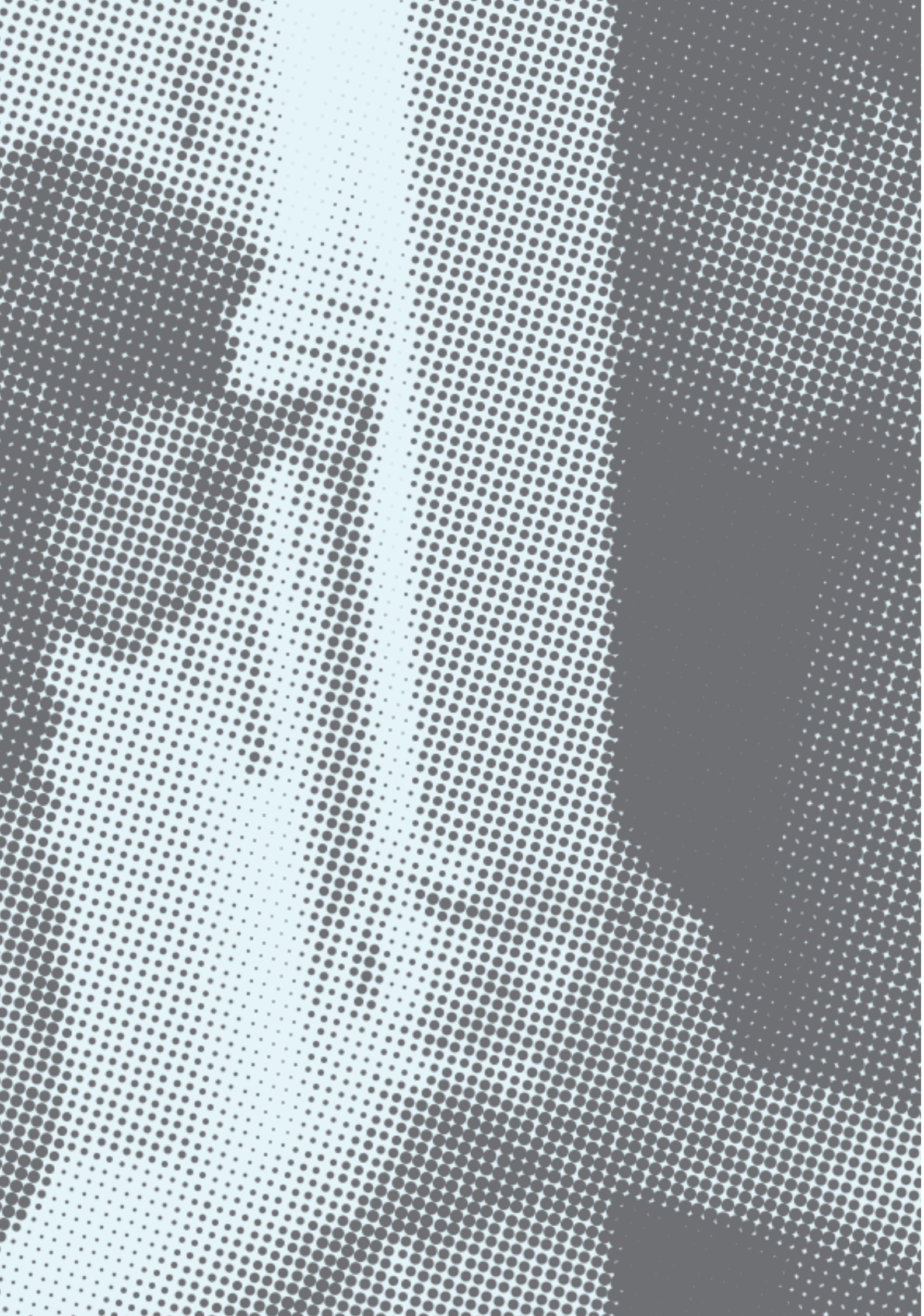


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“IAPT isn’t just about CBT, it’s about implementing NICE guidance. If NICE recommends several therapies for a condition, then patient choice should operate, because people are more likely to get better from something they’ve chosen” – David Clark, National Clinical Adviser for IAPT, interviewed in May 2013

Percentage of sessions delivered in IAPT which are of couple therapy for depression = 0.62% (i.e. 1 in every 161 sessions at Step 3) – *findings from a freedom of information request to all commissioners and providers of IAPT services carried out in October 2013*



Executive summary

This report presents data gathered by the Tavistock Centre for Couple Relationships on the availability of couple therapy for depression in IAPT services.

Couple therapy for depression is the NICE-recommended treatment for mild to moderate depression where there is a distressed couple relationship that appears to be a factor in instigating, maintaining or re-precipitating the depressive symptoms in one partner.

The data presented in this report was gathered via a Freedom of Information request to all clinical commissioning groups and mental health trusts, and a 'mystery shopping' exercise conducted with 20 IAPT services.

Responses to the Freedom of Information request show that only 0.62% of all sessions delivered at the high intensity (Step 3) level in IAPT services were couple therapy for depression appointments. This equates to just one in every 161 sessions, a figure which TCCR believes to be significantly lower than the actual need for such an intervention.

The 'mystery shopping' exercise of 20 IAPT services across the country – in which an agency played the role of a relative of someone who had been made redundant a year previously, and who is feeling depressed and having rows with their partner – found worrying low levels of knowledge among IAPT staff of the full range of NICE-recommended treatments, as well as inappropriate sign-posting by IAPT services to other agencies.

While responses from mental health trusts to the freedom of information request suggest that a small number are in the process of making couple therapy for depression available, the results of this investigation indicate that provision of this intervention is very patchy and, when it is available, is being received by very few couples.

The report concludes with a number of recommendations specifically aimed at commissioners, providers, the Department of Health and Health Education England.

Introduction and background to this report

Couple therapy for depression is the therapy derived from the NICE guidelines' evidence base for the treatment of mild to moderate depression where there is a distressed couple relationship that appears to be a factor in instigating, maintaining or re-precipitating the depressive symptoms in one partner (Hewison, 2011); it is also the intervention of choice where a close relationship might be a necessary support for treatment adherence (NICE, 2009). Evidence shows that the prevalence of depression in the population where the relationship is a factor is sizeable (Whisman and Bruce, 1999) (Whisman, 2001).

TCCR has ongoing concerns that many couples are not getting the help they need within IAPT services; services which should, in theory, offer interventions to treat depression and anxiety in accordance with NICE guidelines. These concerns prompted TCCR to conduct an investigation whose findings this document presents.

Data collected in 2011 (RCPsych, 2011) (and which is due to be updated around the time of publication of this report) suggested that couple therapy was available in just under a quarter of services (24.6%), a figure considerably less than therapies such as interpersonal therapy (IPT) (48.3%), brief psychodynamic therapy (DIT) (39.8%) and individual cognitive behavioural therapy (CBT) (94.9%).

The rationale for suspecting that this intervention may be only very selectively available is based on a number of sources, including:

- information gathered from our own networks (as the accrediting body for the training of practitioners in couple therapy for depression we have a broad overview of the intervention's availability across the country);
- data published by the We Need To Talk Coalition in 2013 (i.e. that 58 per cent of people are not offered choice in the type of therapies they receive) (We need to talk, 2013);
- data published in response to parliamentary questions (see Figures 1 & 2) which reveal the paucity of expenditure on IAPT training fees for couple therapy for depression and the low numbers of practitioners training in couple therapy for depression compared to other modalities;
- the high proportion of couples who present to TCCR's

Figure 1: Estimates for the amount spent on Improving Access to Psychological Therapies programme (IAPT) training fees in each year from 2008-09 to 2011-12 for each modality of therapy*

Type of therapy	2008/9	2009/10	2010/11	2011/12
CBT(at Step 2)	2.190	4.430	2.620	2.680
CBT(at Step 3)	4.870	10.040	6.230	2.910
Interpersonal psychotherapy	0	0	0.258	0.246
Counselling for depression	0	0	0.192	0.204
Brief dynamic therapy	0	0	0.189	0.081
Couple therapy for depression	0	0	0.044	0.207
Total expenditure on IAPT training fees (£M)	£7.06	£14.47	£9.513	£6.328

*Source: Written answers for questions: Hansard 3rd Dec 2012 vol. 554 column 634W

couple counselling and psychotherapy services who would be considered to fall within a clinical range (59%)¹, many of whom will be suffering from depression or anxiety².

Along with the We Need To Talk Coalition, TCCR believes that a genuine choice of therapies should be available to IAPT service users. However, TCCR takes the view that this area does not amount simply to one of choice; rather, we believe that it is of fundamental importance that patients are able to access not only interventions which are based on an individual approach but also those which are couple-oriented. This belief stems from evidence, set out in the following section, about the clinical need for couple-oriented approaches.

Figure 2: Number of trainees in each modality of IAPT therapy for each academic year*

Type of therapy	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	Total
CBT (at Step 2)	510	727	517	536	459	500**	3249
CBT (at Step 3)	487	1004	623	291	322	500**	3227
Interpersonal therapy	0	0	86	82	155	91**	414
Counselling	0	0	64	68	132	266**	530
Brief dynamic therapy	0	0	63	27	58	93**	241
Couple therapy for depression	0	0	44	69	99	85**	297
Total	997	1731	1397	1073	1225	1535**	7958

* Source: Written answers to questions: Hansard 8th Jan 2013 vol. 556 column 258W
**intended

This short report does not set out to critique IAPT; nor does it seek to pitch one particular type or modality of therapy against any other. Rather, the report begins from the standpoint that the IAPT programme needs to offer a more genuine choice of psychological intervention if it is – in keeping with the original aim of the service – to reduce both the incidence of depression and the burden which depression places on the economy.

To this end, TCCR has collected data from clinical commissioning groups and mental health trusts on the numbers of sessions delivered in IAPT at high intensity (Step 3) level, including the number of these that were couple therapy for depression appointments.

TCCR also employed a professional agency to carry out a mystery shopping exercise in order to gather information about the real experience of patients seeking to access couple therapy for depression through IAPT.

This report is written against a backdrop of commitments made by the previous and present Governments. For example:

- “We will work 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, and developing training for other NICE approved interventions to support therapists’ continuing professional development”(Department of Health, 2008).
- “In future, patients and carers will have far more clout and choice in the system; and as a result, the NHS will become more responsive to their needs and wishes. People want choice, and evidence at home and abroad shows that it improves quality”(Department of Health, 2010).
- “The Coalition Government committed the NHS to ensuring that people have a choice of therapy from all those approved by NICE for treating depression” (IAPT Programme, 2012).

We hope that the publication of this report will have a number of results which are set out fully in the recommendations that conclude this report. In short, however, we would hope this report will help to bring about:

- increased, and better informed, commissioning of couple therapy for depression by clinical commissioning groups;
- a more active role being taken by the Department of Health to ensure that those therapies which are recommended by NICE are available to patients;
- the widespread availability of a genuinely couple-focused intervention to treating depression;
- increased, and better informed, commissioning of training for potential practitioners of couple therapy for depression by local education and training boards.

1 As measured by CORE (Clinical Outcomes in Routine Evaluation)

2 Research has found convergent validity of CORE and the Beck Depression Inventory (Barkham et al., 2006)

What is couple therapy for depression and who is it suitable for?

The theory underpinning couple therapy as a treatment for depression is that distressed and conflict-ridden adult couple relationships cause, maintain and provoke further instances of depression in one or both of the partners. The causes of the distress and conflict have a variety of roots:

- patterns of behaviour between the couple that reinforce feelings of blame, hurt, antagonism, and isolation, and which in turn increase depressed feelings and maladaptive behaviours in an attempt to cope
- poor communication skills (meaning the couple are not able to fully articulate or understand each other's needs and wishes and therefore end up feeling misunderstood, ignored, or worse)
- poor negotiating and problem-solving skills around common aspects of adult relationships: sex, money, parenting, relationships with extended family members
- a repeated, reciprocal pattern of complaint and contempt that comes from a sense of not getting one's needs met in the relationship, so preventing each partner from depending on the other and relying on them for help and support
- the repetition of family 'scripts' that each of the couple have and which make them assume that a couple relationship has to be one way rather than another
- the inability to use a close attachment-based relationship as a source of nurture and comfort
- the lack of emotional flexibility and resilience in either or both partners which prevents the couple from recovering quickly or well from both the normal and the exceptional things that happen in adult life, such as the birth of a child, unemployment, bereavement, or an affair.

Couple therapy for depression is relationship-problem orientated, semi-structured, empirically-based and based on psychological methods of treatment. It is a short-term intervention of up to 20 sessions which focuses on a number of key areas in the relationship that reduce stress and enhance support (Hewison et al., In press).

This therapy is specifically developed for use in an Improving Access to Psychological Therapy (IAPT) service as an add-on to therapists' existing couple therapy qualifications. NICE recommendations place the delivery of couple therapy for depression in Step 3 of the Stepped Care model.

The interventions delivered in IAPT services have all been recommended by NICE as being effective for the treatment of depression and anxiety. However, since the Improving Access to Psychological Therapies programme acknowledges that a central aim of the IAPT programme since its inception in 2007 has been "supporting people back to work from a period of sickness absence or a sickness related benefit" (IAPT programme, 2013), it is self-evident that approaches which address those factors which may contribute to difficulties with re-employment will be more successful than those which do not.

Findings from a meta-analysis, which concluded that lack of social support by partners has negative effects on the physical and psychological health of the unemployed person, and is especially associated with more frequent development of psychosomatic symptoms, stress and depression (McKee-Ryan et al., 1987), suggest that services which aim to help depressed people into work should include a couple-oriented approach in their range of treatment options.

Furthermore, a number of other studies give added weight to the view that couple-focused approaches should be universally offered. These include studies which have demonstrated that:

- reductions in supportive behaviours and increased undermining behaviours towards a recently unemployed partner have adverse effects on satisfaction with the relationship and on depressive symptoms (Vinokur and Price, 1996);
- social undermining by one's partner is a significant psychological barrier to reemployment (Vinokur et al., 2000);
- a positive and uncritical stance towards one's partner can counteract such depression-inducing effects, particularly

among those who are highly motivated to look for reemployment (Vinokur and Caplan, 1987), a group that is at higher risk for depression (Howe et al., 1995).

The data set out in this report indicates that we could be doing much more in IAPT services to take account of studies which show, firstly, that the outcome of depression of patients living with partners is associated with the degree of criticism expressed by the partner towards the patient (Vaughn and Leff, 1976) (Hooley et al., 1986, Okasha et al., 1994), and, secondly, that the risk of depression is greatest among those with the poorest overall relationship quality (judged by assessing how often their partner is critical and/or overly demanding) (Teo et al., 2013).

What, however, is the degree of need within the population for such an approach to tackling depression?

There are no absolute figures for this; however, authors of a study conducted in 1999 of over 900 married individuals who did not have depression at the outset of the study concluded that '20% to 30% of new occurrences of major depressive episodes could be prevented if marital dissatisfaction could be eliminated' (Whisman and Bruce, 1999). Furthermore, researchers who conducted a meta-analysis published in 2001 found marital dissatisfaction to be 'associated with both depressive symptoms and diagnostic depression' (Whisman, 2001) and a mean correlation between marital distress and major depression of .66 (that is, 66% of the variation in major depression is explained by the variation in marital distress – a strong correlation in statistical terms).

More recently, a study of nearly 5,000 adults has shown that the quality of a person's relationships with their partner predicts the likelihood of major depression disorder in the future (Teo, 2013). This research found that one in seven adults with the lowest-quality relationships were likely to develop depression as opposed to one in 15 with the highest quality relationships; and that people with unsupportive partners were significantly more likely to develop depression, whereas those without a partner were at no increased risk.

Research strongly suggests therefore that the prevalence of depression in which the relationship is a factor is sizeable. And yet, this investigation has found that only 0.62% of sessions delivered in IAPT at high intensity (Step 3) level are for couple therapy for depression.

The following two case studies are included to illustrate the kinds of scenarios where a couple-focused approach to treating depression is the most appropriate.

Case study 1

Fatima (42) and Mark (49) have been together for 25 years and have two teenage daughters. Fatima has suffered from mental health problems over many years. Last year Fatima had a course of CBT which her GP had recommended after she had been signed off sick from work because of her anxiety about her health. She briefly returned to work following the therapy, but further repeated short absences eventually led to her losing her job.

When Fatima presented to her GP on one occasion with an infected wound on her arm arising from self-harm, her doctor enquired more deeply than before about her family life. Mark and Fatima had had many years of unhappiness, it emerged; indeed, Mark was currently threatening to leave the family home. The GP referred Fatima and Mark to couple therapy for depression through the local IAPT service.

The impression the therapist received from the referral letter was that Fatima was the 'identified patient' (the one with depression) and that Mark was an apparently well, but uncertainly connected partner. When she met the couple, however, she was surprised to find that Fatima was a self-possessed, professional-looking woman able to articulate her concerns about herself and their relationship. In contrast, Mark was agitated, rather dishevelled and inarticulate about anything except why Fatima needed help. This seemed to be 'because she had become different', and he worried about whether she was about to break-down. He appeared oblivious to his own fragile state.

In the early stages of therapy Mark was adamant that the problems were Fatima's and was at a loss to understand why she was so unable to snap out of it. He thought that he provided her with everything she needed, and so she had no real reason to be unhappy. He dismissed attempts by the therapist to identify this as a difficulty in their relationship.

Without allowing Mark to deflect his feelings onto Fatima, the therapist drew Mark out about his own sense of panic and distress at the time when Fatima, a year earlier, had attempted suicide. This enabled similarities between their distress to become more apparent, in particular their shared feeling of not being good enough, without triggering accusation and anxiety.

Fatima and Mark attended the full 20 sessions of therapy. A few sessions before the final session their therapist asked them for any thoughts they might have about ending, and what they had made of the process.

Fatima said that she wished they'd had this type of help a long time ago. She hadn't found the various individual-based therapies she had had in the past

particularly useful, partly because they always left her feeling like she was the problem whenever she brought any relationship issues for discussion.

Mark said it felt like they were making a fresh start. The previous ten years had been a struggle, almost as though they had been wiped out, and now there was some hope that they could go in a different direction. He said he was sad when he thought about his role in Fatima's distress, and he realized that he must shoulder his own burdens, despite how difficult this sometimes felt. He laughed when he said that in some ways he was more of a patient than Fatima, despite her being the one with the 'official' history of distress. He thought they now understood much more about each other's emotional state and what underlay it.

Case study 2

Helen, 32 years old, and Karen, 38 years old, came to therapy because their relationship has been suffering since Karen was diagnosed with depression.

Karen feels that she has lost her "appetite for life". She finds life tiring and feels drowsy and low most of the time. She used to work as a nurse but she left her job when the day unit she worked in merged with another. She had decided that she was going to take a different direction but so far she has struggled to find new work. Karen has an 8 year old son who is very challenging and, after much back and forth to doctors, has recently been diagnosed with ADHD.

Karen has been taking anti-depressant medication for nearly a year. It has helped somewhat but she is still not working and her relationship with her partner Helen has now come under such strain that a friend suggested that they should see a couple counsellor.

The couple have been together for four years. Helen had other lesbian relationships before, whilst for Karen this was her first sexual relationship with a woman. When she met Helen she had just been left by her male partner and was feeling betrayed and lonely. She is very afraid that Helen will also leave her. She is also anxious that she could not cope on her own.

Helen asked her GP whether there was any opportunity through the NHS for the couple to get some help for their relationship. Helen feels that they used to have friends around and socialise almost every night but over the last two years Karen has gradually become withdrawn. Their sexual life has come to a halt and they have ended up more like friends. Helen said that if they cannot "fix" their sexual life they would have to separate. Whilst Helen cares for Karen she feels she is also now depressed and can no longer bear to live with someone who seems so negative and self-hating. Helen is also unsure she can go on carrying them both financially and finds living with Jack, Karen's son, very difficult.

While sympathetic, her GP could only offer her the name of a private couple counsellor at a cost of £65 per session – an amount that the couple cannot currently afford – as their local IAPT service does not provide couple therapy for depression. Both Helen and Karen feel that what their GP can offer Karen – a course of psychological therapy on an individual basis – will do little to help their current situation together.

What is the current availability of couple therapy for depression?

On 27th September and 3rd October 2013 the Tavistock Centre for Couple Relationships submitted freedom of information requests to all clinical commissioning groups and mental health trusts respectively. The request asked for information as shown in the box below:

Regarding the delivery of high-intensity (Step 3) level interventions through IAPT, please could you provide the following data:

1. In the first quarter of 2013-14 (i.e. 1st April to 30th June 2013) how many sessions of high intensity (step 3) level interventions did the IAPT service which your clinical commissioning group/mental health trust commissions/provides deliver in total?
2. Of these, how many were sessions of Behavioural Couples Therapy (also known as Couple Therapy for Depression)?
3. What is the waiting time for someone who is referred for Behavioural Couples Therapy (also known as Couple Therapy for Depression)?
4. What is the waiting time for someone who is referred for Cognitive Behavioural Therapy (as a high intensity/step 3 level intervention)?

Of the 211 clinical commissioning groups approached, 26% responded with data, 40% responded saying that they did not hold the data and 34% did not respond at all. Of the 53 mental health trusts approached, 66% responded with data, 8% responded saying that they did not hold the data and 26% did not respond at all.

In many cases when clinical commissioning groups responded saying that they did not hold the data they advised us to approach the relevant mental health trust for it. As some mental health trusts responded with data for a number of clinical commissioning groups it is not possible to give an overall figure for the total response rate for this freedom of information request. However, it is likely – given the response rate from clinical commissioning groups plus from mental health trusts – to be in the region of 80-90%. Results of the freedom of information request are set out in the table below:

Total no. of step 3 sessions delivered by IAPT	285,157
Total no. of sessions of couple therapy for depression delivered by IAPT	1,789
Couple therapy for depression sessions delivered as proportion of total	0.62%
Average waiting time for couple therapy for depression (in days)	39
Average waiting time for cognitive behavioural therapy (in days)	59

Patient experience: what actually happens when you try to access couple therapy for depression through IAPT?

During October 2013, an agency specialising in 'mystery shopper' calls was contracted by TCCR to make 20 telephone enquiries to randomly selected IAPT services (spread across the country) accepting self-referrals. The scenario which the caller described is detailed in the box below:

Instructions to mystery caller from TCCR

1. You are very worried about your sister/brother/father/mother. He/she was made redundant about a year ago, is feeling depressed and is having difficulties/rows with their partner. [NB – very important that both depression and difficulties with the partner are mentioned at this point]. He/she has seen their GP and was diagnosed as being depressed; at which point you believe they had a conversation about exploring talking therapies but you don't think that your sister/brother/father/mother has made any further enquiries.
2. You know that your sister/brother/father/mother had CBT counselling a few years ago and that they really didn't get on with that approach. You are wondering whether this is partly what is holding them back from making an enquiry about some psychological help/counselling now.
3. Can the IAPT service please tell you what else might be available for your relative, particularly in light of the difficulties she is having with her relationship, which you feel is compounding her depression? [PROMPT 3a. If, at this point, the IAPT service doesn't specifically mention couple therapy for depression, say something to the effect of 'I was reading on the internet the other day that there's something called couple therapy for depression that you can get through this service – is that correct?']
4. If it is possible to be referred to this type of therapy, you would like to know what the waiting time would be
5. If it isn't possible to get this type of therapy, you would like to find out why this is the case when – as you understand it – your sister/brother/father/mother is entitled to a choice of therapy and you really don't feel that CBT or another treatment that just deals with him/her as an individual is really going to work for them.

Results from this exercise make fascinating, if alarming, reading. Some of the more prominent themes and issues are explored below.

IAPT advisor knowledge about range of NICE-recommended treatments

The scenario used in these mystery shopper calls was constructed in such a way that there could be no doubt that – of the range of therapy NICE recommends for the treatment of depression – couple therapy for depression was the most appropriate treatment. It is therefore remarkable that 16 of the 20 advisors made no mention of couple therapy for depression when this scenario was described to them.

The focus of this report is not on how well or otherwise IAPT advisors deal with enquiries from members of the public. However, it should be noted that callers only rated one of the calls as being dealt with 'poorly'; the remaining 19 were judged to have been handled in an 'excellent', 'good' or 'ok' manner.

This would suggest that it is not the customer care side of the work which IAPT advisors need to improve but rather their general level of knowledge about the range of services which NICE recommends for the treatment of depression. At the very least, one should reasonably be able to expect that IAPT advisors will be aware of this range of services and acknowledge that, in too many cases it would seem, their particular service is unable to provide what is clearly the most appropriate treatment. Were this to happen, it would amount to a useful intelligence tool for IAPT services – feedback from advisors about the need for particular approaches to be offered should surely be captured by those services as they seek to develop and become more patient-focused.

'The advisor didn't mention the couple therapy for depression, even when I prompted her several times about my sister and her partner having difficulties and constantly rowing'.

'Yes, the advisor said that the counselling service do offer Couple Therapy for Depression and it is not necessarily relationship-based.'

If couple therapy for depression was not available, what services were being offered?

'Only CBT and psychiatrist available'

'It is not available through their services but is available through Relate. They can sometimes work with Relate but they would be seen individually - they do not see anyone as a couple in the same room at the same time.'

'The advisor clearly said that they did not offer couple therapy and I would need to speak to Relate.'

'When I mentioned the couples therapy, the advisor just seemed to go completely off track and just recap on what she had said about the CBT and going back to the GP. Speaking to this advisor, it almost seemed that couples counselling is something way down the line and not the thing that she was readily promoting which was individual counselling first, CBT.'

It is striking that so many of the services approached for the mystery shopper exercise mentioned Relate. With 65 centres, Relate is by far the biggest provider of couple counselling across the country. Despite the fact that many Relate centres aspire to provide couple therapy for depression, and that it has the workforce arguably most suitable to be trained to deliver the intervention, Relate is currently commissioned to deliver it for IAPT in only nine centres.

Last year approximately 101,000 couples were supported by Relate, predominantly receiving couple counselling over six sessions. Six sessions of couple counselling is not the same however as the 15-20 sessions of couple therapy for depression which NICE has recommended for delivery in IAPT services. It is significant therefore that the NHS is sign-posting people to a service which generally makes a different offer than that recommended by NICE.

This in no way amounts to a criticism of Relate, whose counsellors provide appropriate and effective relationship support, but simply to point out that the counselling which couples generally receive from Relate is not necessarily aimed at nor developed for the population which couple therapy for depression is intended to treat. Relate, whilst a charity, also has to charge for its services to make them viable and, although it tries to make its services accessible (given that costs can be prohibitive for some clients), it cannot provide a free service to everyone – a factor which introduces a lack of equity for patients with depression where the relationship is the precipitating or maintaining factor.

'It may be a good idea to speak to Relate.'

'When I prompted the advisor, more than once about the fact that I had heard about Couple Therapy for Depression, she said that they do not offer that service here and perhaps it may be a good idea to speak to Relate as they would be able to deal with my sister and her partner together as a couple.'

'No, she said the words that it wasn't available there and that I would have to go for Relate for this as they only dealt with CBT on a one to one basis.'

Grounds for optimism

It is only minimally encouraging that one of the IAPT services contacted by the mystery shopping exercise indicated that their service was in the process of developing an offer of couple therapy for depression.

"Yes it is available but they aren't starting the course until the middle of November. They are working with RELATE now so it will be free under the NHS. She did not think that there would be a wait as it is a new service".

More hopeful, however, are results from the freedom of information request which reveal that a number of commissioners and providers are in the early stages of providing couple therapy for depression to their patients.

"We offered no Behavioural couples therapy (BCT) sessions during this period – we trained our first therapist in this mode of treatment at the end of April 2013. Since June 2013 we have provided 9 sessions of BCT".

"The Trust only delivered 4 sessions of couples therapy during this period as this was a new area of work for us which commenced as part of a new contract in April 2013".

"There is a training course being held in November 2013 for Couples Therapy for Depression for further staff to be trained".

"Offering Behavioural Couples Therapy is part of our service development plan, we are recruiting staff with diverse skill sets to offer this intervention".

Discussion and recommendations

The fact that, as this investigation has uncovered, that a mere 0.62% of the sessions delivered by IAPT services at high intensity (Step 3) level are of couple therapy for depression is disappointing. For while there are no absolute figures available to the prevalence of depression in which the couple relationship is a factor in instigating, maintaining or re-precipitating the depressive symptoms in one partner, to argue that this is the case in only one in every 161 presentations would not be credible.

The high numbers of commissioners and providers of IAPT services who could not provide data broken down by modality is similarly alarming, suggesting that a lack of clear direction or understanding of best practice (although TCCR understands that the Department of Health will be publishing this data in January 2014).

The general lack of knowledge among IAPT staff responding to enquiries from the public about couple therapy for depression and the range of services which NICE recommend for the treatment of depression is also worrying, as is the propensity to signpost members of the public to other providers of couple counselling, regardless of the level of severity/clinical need of those people.

The data – not uncovered by this investigation but published again in this report – regarding expenditure on training, and numbers of trainees, for IAPT therapies is also an ongoing cause for concern, given the unacceptably low numbers for both in relation to couple therapy for depression.

In light of the above issues, the Tavistock Centre for Couple Relationships recommends the following as a joined-up approach to ensuring that the availability of couple therapy for depression in IAPT services increases to a level appropriate to the need for it in the population.

Recommendations for the Department of Health

- The Department of Health to ensure that those therapies which are recommended by NICE are actually available to patients;
- The revised NHS Mandate to include a new target such that the IAPT programme is required to provide choice of a person's preferred NICE-recommended therapy.

Recommendations for clinical commissioning groups/ commissioners of IAPT services

- increased, and better informed, commissioning of couple therapy for depression by clinical commissioning groups;
- clinical commissioning groups commissioning couple therapy for depression should do so on the basis that the fee paid to providers is commensurate with, and sufficient to cover, the number of sessions (15-20) necessary for couple therapy for depression to be delivered in accordance with the evidence base as set out in the NICE guidelines on depression.

Recommendations for providers of IAPT services

- IAPT service providers should ensure that staff dealing with the public have a general level of knowledge about the range of services which NICE recommends for the treatment of depression.

Recommendations for Health Education England

- to use their leadership role to bring about increased, and better informed, commissioning of training for potential practitioners of couple therapy for depression by local education and training boards.

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Established in 1948, The Tavistock Centre for Couple Relationships is recognised in its field as a centre of advanced practice and study, both nationally and internationally. Our ethos is to develop practice, research and policy activities which complement and inform the development of services to couples.

We run a variety of practitioner trainings, ranging from introductory courses to doctoral programmes in couple counselling and psychotherapy. Our courses are accredited by the British Association of Couple Counselling and Psychotherapy, the British Psychoanalytic Council and the College of Sexual and Relationship Therapists. Our trainings are validated by the University of East London (UEL).

TCCR also supports the work of frontline practitioners, and aims to foster an approach to family support and mental health service provision which takes the impact of couple relationships on child and family functioning into account.

In addition, we undertake research and policy activities which encourage the development and growth of effective and innovative relationship support services.

TCCR also provides services to couples and parents throughout London. We operate a range of affordable counselling and psychotherapy services supporting clients experiencing challenges in their relationships, their sexual lives and their parenting.

TCCR is a part of The Relationships Alliance, a consortium comprising Relate, Marriage Care, One Plus One and the Tavistock Centre for Couple Relationships, which exists to ensure that good quality personal and social relationships are more widely acknowledged as central to our health and wellbeing.

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