The Wellbeing Course for adults with depression

2 September 2019

Summary

• The technology described in this briefing is the Wellbeing Course. It is an online cognitive behavioural therapy (CBT) course designed to treat depression and generalised anxiety disorder (GAD).

• The scope for this briefing is to consider the use of the Wellbeing Course to treat depression in a therapist-guided model of care, in adult Improving Access to Psychological Therapies (IAPT) services, for the NHS England evaluation of digitally enabled psychological therapies for IAPT.

• The intended place in therapy would be as a step 2 or step 3 therapy, as an alternative to face-to-face CBT. It would be delivered with support and guidance from a therapist.

• The main points from the evidence summarised in this briefing are from 3 randomised controlled trials set in Australia including a total of 460 people. Of these 170 had a diagnosis of depression. They show that the Wellbeing Course improves symptoms of depression and is more effective than waiting list control (that is, no treatment).

• Key uncertainties around the evidence are:
  – the study populations may not be fully representative of users in adult IAPT services
  – there is no evidence comparing the Wellbeing Course with face-to-face CBT
  – the study populations were not solely people with depression.

• The cost of the Wellbeing Course in the UK is not yet available but is expected to be around £70 per person. This includes licence costs of £39 (including VAT) and 1.5 hours of a psychological wellbeing practitioner’s (PWP) time per person. The resource impact would be similar to standard care but may free staff time to deal with more dependent people.
The IAPT expert panel did not recommend the Wellbeing Course for the evaluation in practice phase of the NICE and NHS England IAPT assessment programme. The panel concluded that the Wellbeing Course did not meet the requirements of, or provide acceptable remediation plans for, the technical assessment. The panel also noted that the transdiagnostic approach used does not cover all the elements that would be expected to be included in a course focused on depression.

The technology

The Wellbeing Course (MQ Health) is an online programme that uses the principles of CBT to treat depression and GAD. The Wellbeing Course can be used as a standalone self-help tool, either online or in printed workbook format. The focus of this briefing is on its use in an online, therapist-guided model of care for treating depression.

The content of the Wellbeing Course is delivered in 5 modules over 8 weeks with a spacing of 1 to 2 weeks between lessons. Each lesson targets specific symptoms and teaches CBT-based skills. Content is designed to build on previous content and includes educational material and service user stories.

Each lesson has a core module with additional exercises that users can work through if they or their therapist think they’re relevant:

- Lesson 1 (week 1): Introduction explaining how to use the course. Core module on the cycle of symptoms and symptom identification, and an optional good sleep guide.
- Lesson 2 (week 2): thoughts and thought challenging with optional modules on managing beliefs, structured problem solving and worry time.
- Lesson 3 (week 4): symptoms and spirals of over-arousal and under-arousal with optional modules on communication skills and mental skills.
- Lesson 4 (week 5): avoidance and safety behaviours and starting to use graded exposure with an optional module on assertive communication.
- Lesson 5 (week 7): managing lapses and staying well.
Users have access to the Wellbeing Course for 9 months after registration. The course is supposed to be completed in about 8 weeks but this can be changed to suit the user.

When used in a therapist-guided model of care, the user completes self-test questionnaires (Patient Health Questionnaire 9 [PHQ-9] and Generalized Anxiety Disorder assessment 7 [GAD-7] scores) at the start of every session. The therapist can see and comment on a person’s progress through each session. The therapist who reviews progress can be changed if there is clinical need, for example, if someone progresses from step 2 to step 3 therapy.

Users receive therapist follow-up contact at week 8 (course completion) and 3 months after treatment. Users get monthly automated emails to encourage ongoing review and practice for 3 months after treatment.

Users are encouraged to download and print relevant content and homework worksheets.

The programme can be accessed on any device that has internet access. Users log in through an encrypted website, using their own login and password.

**Regulatory status**

The Wellbeing Course has no regulatory status in the UK. The technology owner has stated that the Australian Department of Health and the Australian Commission for Safety and Quality in Health Care have advised that the Wellbeing Course does not currently fall within the scope of the Therapeutic Goods Administration which regulates medical devices in Australia.

**Current usage and reach**

The technology owner has stated that the Wellbeing Course is not currently in use in the UK. However, since 2012 more than 16,000 adults in Australia and more than 3,000 adults in Canada have used the course via mental health or
primary care services. Of these, approximately 7 to 10% of users have requested printed materials as an alternative to using the online programme.

**Current care pathway**

The NHS England Adult Improving Access to Psychological Therapies (IAPT) programme aims to provide evidence-based treatments for people with common psychological conditions such as anxiety and depression. IAPT services offer evidence-based psychological therapies given by accredited practitioners, with routine monitoring and regular outcomes-focused supervision.

The care pathway for depression is described in the NICE guideline on depression in adults, depression in adults with a chronic physical health problem and common mental health problems. NICE recommends a stepped-care model for treating depression, in which the least intrusive, most effective intervention is provided first. If a person does not benefit from the intervention initially offered, or declines an intervention, they should be offered an appropriate intervention from the next step.

The Wellbeing Course could be used in a therapist-guided care model in secondary care, or in IAPT services as a step 2 and step 3 therapy. It is not anticipated that any changes would be needed to the current care pathway.

**Population, setting and intended user**

The Wellbeing Course could be used in any setting in which the user has access to the internet, including at home or in outpatient clinics. It would be used by adults with depression, in a therapist-guided care model with an appropriately trained therapist. In IAPT services this would likely be an appropriately trained PWP.

The technology owner states that no special training is needed to use the Wellbeing Course and a step-by-step guide is provided.

Therapists and administrators need orientation and training. In Australia and Canada therapists are trained in a 3-day workshop and administrators get a 2-
day training programme. The technology owner states they are developing online training for IAPT staff but they have not yet established a formal cost model for this.

**Equality considerations**

NICE is committed to promoting equality, eliminating unlawful discrimination and fostering good relations between people with particular protected characteristics and others. In producing guidance and advice, NICE aims to comply fully with all legal obligations to: promote race and disability equality and equality of opportunity between men and women, eliminate unlawful discrimination on grounds of race, disability, age, sex, gender reassignment, marriage and civil partnership, pregnancy and maternity (including women post-delivery), sexual orientation, and religion or belief (these are protected characteristics under the Equality Act 2010).

The Wellbeing Course may improve access for hard to reach populations with depression. For example, young men and men from minority backgrounds, who may prefer to engage with digital services rather than face-to-face interventions.

Digital technologies such as the Wellbeing Course may be unsuitable for people with visual impairment or learning disabilities. Disability is a protected characteristic under the Equality Act.

**The content**

**Care model**

The Wellbeing Course can be used in self-guided or therapist-guided formats online or offline using printed materials. The self-guided format is beyond the remit of this programme.

The software platform is managed by the MindSpot Clinic with individual dashboards for service users. Therapists have their own dashboard which allows them to monitor and manage service users. They can monitor service user progress, see service user reported outcome measures (PHQ-9 and
GAD-7 scores), enter progress notes, send and receive secure messages, and identify concerns. The therapist completes a progress or supervision note at least weekly for every active service user.

The therapist should also:

- Help users progress by encouraging them to apply their new skills, answering questions, discussing lesson content, and helping them to solve problems.
- Keep telephone calls succinct and focused. Most users are considered to only need 5 to 10 minutes of clinician contact time each week.
- Give feedback and make recommendations based on the user’s progress and clinical needs. This may include adjustments to contact arrangements if, for example, someone may benefit from longer and more intensive contact or withdrawal and external referral.

There are 5 homework assignments in the Do It Yourself (DIY) Guides that users are encouraged to print out. These summarise the lesson content, provide worksheets for the user to complete and include case examples. Therapists cannot see the worksheets, but the technology owner states that most therapists will discuss homework with the user.

A comprehensive therapist manual describes how to support and communicate with users through the course. It also includes a list of helpful things to remind service users about.

Users also have optional modules about topics like sleep hygiene and communication skills.

**Outcome measures**

The Wellbeing Course uses the PHQ-9 and GAD-7 outcome measures that are needed for use in IAPT services. The technology owner has stated that therapists will be able to review each user’s individual outcome measures.
Content assessment

The therapeutic content of the Wellbeing Course was assessed using a framework designed to measure how closely its content maps to the standard principles of CBT for depression (Beck model).

The technology owner states that the Wellbeing Course uses the following CBT principles:

- psycho-education
- cognitive therapy (recognition of thoughts and beliefs, and challenging)
- management of under-arousal (and hyper-arousal)
- behavioural activation and re-engagement
- graded exposure
- relapse prevention.

The content assessors reported that the Wellbeing Course uses a transdiagnostic approach. This means that the approach is used to treat different disorders. The course aims to help people with depression and GAD, and other disorders such as worry, social phobia, panic, obsessive-compulsive disorder and post-traumatic stress disorder. The transdiagnostic approach means that the course content is the same for depression and for GAD.

The assessors also noted the following points about the Wellbeing Course:

- It is clear, well-constructed and easily navigated. Users can access information in different ways and at different levels with concrete examples backing up the more abstract information. However the slide sets for each lesson are long.
- The severity of the condition being targeted is not clear.
- The programme uses a transdiagnostic approach to treat depression and a number of anxiety disorders. Because of this it does not cover everything that would be expected in a course focused on a specific condition.
• The cognitive model for depression was not covered, including support with understanding of core beliefs, processing biases and the role of interpersonal factors.
• Users were not helped to identify and clarify concerns through ‘chief complaints’ or ‘chief problems’, identifying ‘personal paradigms’ and identifying coping mechanisms.
• The course lessons are one way only, and do not take advantage of opportunities for interactive learning and teaching.
• The case examples were well structured.
• The programme makes it clear that many of the exercises will be challenging at first, that this is normal, and that users should not be discouraged if this applies to them.
• Patient safety was well handled (assuming that the manual provided separately is adhered to), but it was not clear how the programme applies to a stepped care model. There is no GAD-7 or PHQ-9 score threshold to indicate that the user’s condition is worsening and that they need higher intensity input. But therapists should apply clinical judgement at weekly reviews.

**Scalability**

The technology owner has stated that any additional increase in users from the NHS following evaluation through this programme could be managed within current capacity. This includes technical and service enquiries. Therapists are also trained on minor technicalities such as resetting passwords.

**Technical standards**

**Technical assessment**

The Wellbeing Course has had a technical evaluation using relevant sections from version 2.1 of the Digital Assessment Questions (DAQ), a tool developed by NHS Digital and currently available to developers in beta form. The evaluation included 6 domains of the DAQ: clinical safety, data protection, security, usability and accessibility, interoperability and technical stability.
Questions from the DAQ on technologies for children, and questions about the evidence base were omitted from this evaluation.

The technical assessors identified concerns in all but the security domain. The technology owner provided remediation plans to address issues identified in the domains of clinical safety, data protection, usability and accessibility, interoperability and technical stability.

The assessors noted that the remediation plans for clinical safety and data protection would require a 6-month implementation period to comply with:

- the NHS’s [DBC0129 standard](#) on clinical risk management in health IT systems, including making sure staff and processes meet its requirements
- [General Data Protection Regulation (GDPR) requirements](#) for compliance with EU law on data protection and privacy.

The assessors said the remediation plans for meeting the requirements in the usability domain were acceptable.

They said they could not fully assess the interoperability and technical stability domains because some questions remained unanswered.

The technology owner did not provide enough acceptable information for remediation in the interoperability domain. In particular, there was not enough acceptable information about proprietary formats used to store or transfer data, and the exposure of APIs (application programming interfaces).

The assessors also reported that the remediation suggested for technical stability was not enough to address concerns about accreditation to industry wide testing standards, and about the level of testing for the digital service.

Overall, the assessors reported that the Wellbeing Course must have significant remediation to pass the technical assessment.

The technology owner has stated it could not fully complete the DAQ because it needed information on the final business model for the Wellbeing Course in the UK, including server and data location, which they do not know yet. The
technology owner said it was confident it can address these technical requirements if the Wellbeing Course is selected for the NHS England evaluation in practice stage of the programme.

Clinical evidence

A literature search was carried out for this briefing in accordance with the process and methods statement. This briefing includes the most relevant or best available published evidence relating to the clinical effectiveness of the technology.

This briefing summarises 3 randomised controlled trials set in Australia involving a total of 460 people. Of these 170 had a diagnosis of depression.

The technology owner cited a number of additional published studies that are not included in this briefing. These include randomised controlled trials evaluating different forms of the course, conducted on different populations and other feasibility studies.

Overall assessment of the evidence

Four published papers relating to participants recruited as part of 3 randomised controlled trials report on the effectiveness of the Wellbeing Course. In all studies there were significant reductions in symptoms of depression after the Wellbeing Course. Between group effect sizes varied from small to large.

All studies were done in Australia. In Australia, the Wellbeing Course is used transdiagnostically. None of the studies compared the Wellbeing Course with standard practice. In the IAPT care pathway standard practice is face-to-face CBT. All studies compared the Wellbeing Course with waiting list controls. Two studies included a subsample of people with depression but were not solely conducted on people with depression. One study was conducted entirely on people with depression, although in this case one of the inclusion criteria was a diagnosis of both depression and GAD. One study was carried out on university students. For these reasons, the available evidence is not
fully representative of how the Wellbeing Course would be used in IAPT services.

The technology owner is a co-author on all the randomised controlled trials, and the published economic analysis.

Table 1 Summary of evidence Terides et al. 2018

| Study size, design and location | N=148  
A subgroup of 55 participants met diagnostic criteria for depression defined as ‘major depressive episode’. Randomised controlled trial. This study evaluated CBT use and life satisfaction as well as GAD and depression. Australia. |
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<tbody>
<tr>
<td>Intervention and comparator(s)</td>
<td>Self-guided version of Wellbeing Course (internet-delivered CBT) compared with deferred treatment waiting list control group.</td>
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</table>
| Population                    | Australian residents seeking online treatment for GAD, depression or both.  
All participants had at least mild (GAD-7 score ≥5) anxiety and at least mild (PHQ-9 score ≥5) depression. |
| Key outcomes                  | The treatment group receiving the Wellbeing Course reported significantly lower depression and anxiety symptoms compared with the waiting list control group after treatment.  
PHQ-9 scores  
Entire treatment group (n=65), mean, (standard deviation [SD])  
Pre-treatment 10.82 (5.24)  
Post-treatment 6.78 (5.64)  
3-month follow up (6.91) (5.72).  
Entire control group (n=75), mean, (SD)  
Pre-treatment 10.19 (5.20)  
Post-treatment 8.90 (5.54)  
3-month follow up – not applicable  
Between group effect size for symptoms of depression was small (0.38, 95% confidence interval [CI] 0.04 to 0.71). |
Improvements in PHQ-9 scores were maintained at 3-month follow up.

PHQ-9 scores specific to the depression subgroup were not reported.

48 out of 65 in the treatment group and 66 out of 74 (1 drop out) in the control group completed post-treatment questionnaires. 13 (20%) in the treatment group and 8 (11%) in the control group did not respond at 3 months (no reasons given).

**Strengths and limitations**

PHQ-9 scores were reported for the entire population only, therefore the scores for those without depression are also included in the mean values. It is not clear the effect this would have on the overall result.

The self-guided version of the Wellbeing Course is different to how it would be used in IAPT services.

Study participants were seeking online treatment for symptoms which may inflate the treatment effect.

There were no statistically significant differences in patient demographics between groups but 88% of the treatment group and 75% of the control group were female.

There was a high level of university educated participants (77% and 67% respectively) which may not be representative of the IAPT population.

**Table 2 Summary of evidence** *Mullin et al. 2015*

<table>
<thead>
<tr>
<th>Study size, design and location</th>
<th>N=55 with anxiety or depression Randomised controlled trial Australia</th>
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<tr>
<td>Intervention and comparator(s)</td>
<td>UniWellbeing Course with weekly support from a clinician compared with delayed-treatment waiting list control group.</td>
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<tr>
<td>Population</td>
<td>University students with major depressive episode (PHQ-9 ≥10) (n=18).</td>
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<tr>
<td></td>
<td>26 students in the study had more than one diagnosis.</td>
</tr>
<tr>
<td>Key outcomes</td>
<td>Statistically significant reductions were found in the clinical subsample with major depressive</td>
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episode with reportedly large effect sizes. These reductions were maintained at 3-month follow up.

Depression subsample (n=31) – PHQ-9 score, mean (SD)

Treatment group (n=20)
Pre-treatment 14.10 (3.62)
Post-treatment 8.33 (4.86)
3 months 5.60 (4.22)

Control group (n=11)
Pre-treatment 14.63 (3.35)
Post-treatment 13.37 (7.42)
3 months – not applicable

Pre-treatment to post-treatment within group effect size d=1.33 (95% CI 0.62 to 1.99).

Post - between group effect size 0.91 (95% CI 0.12 to 1.66).

Strengths and limitations

The UniWellbeing Course had minor adaptions to the standard Wellbeing Course, but there were reportedly no changes to course content. The number of lessons delivered to participants changed twice during the course of the study but the course content and core skills reportedly remained the same regardless of number of lessons.

The study population were university students attending the same university.

There were significantly more participants with a greater number of diagnoses in the treatment group than the control group.

Attrition: 2 people dropped out before starting. 9 people (of 30) dropped out in the treatment group, increasing to 12 by 3-month follow up. 2 people (of 23) dropped out from the control group (based on the entire population).

Table 3 Summary of evidence Titov et al. 2013

<table>
<thead>
<tr>
<th>Study size, design and location</th>
<th>N=257</th>
</tr>
</thead>
<tbody>
<tr>
<td>Randomised controlled trial</td>
<td></td>
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<tr>
<td>Australia</td>
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<table>
<thead>
<tr>
<th>Intervention and comparator(s)</th>
<th>Treatment groups:</th>
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<td></td>
<td>• treatment (Wellbeing self-guided course) with automated emails group (TEG; n=100)</td>
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<tr>
<td>Population</td>
<td>People with elevated symptoms of anxiety and depression (overall sample and depression subgroup reported) who were visitors to a research website that evaluates internet treatments.</td>
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</table>
| Key outcomes | Overall sample Those with and without self-reported depression (PHQ-9 scores of ≥9): there was no significant difference in PHQ-9 scores between treatment groups at post-treatment or at 3-month follow up. However significant differences between both treatment groups and waiting list controls were reported.  
Depression sample (PHQ-9 ≥10) n=85  
TEG n=33, TG n=29, controls n=23  
There was a statistically significant improvement in PHQ-9 scores in both treatment groups from pre to post-treatment but not from post-treatment to follow up. Participants who received automated emails had significantly less depression symptoms at post-treatment and 3-month follow up than those who did not. |
| Strengths and limitations | The intervention was used transdiagnostically. Attrition: automated emails appeared to reduce drop outs with 34% of the TG dropping out before completing lesson 3 compared with only 11% of the TEG.  
84% (TEG), 89% (TG) and 84% (controls) completed post-treatment questionnaires. Did not compare with standard care (face-to-face CBT). |

**Table 4 Summary of evidence** Titov et al. 2014

| Study size, design and location | This study evaluated 12-month follow-up data from the original study sample in Titov et al. 2013. |
| Intervention and comparator(s) | See Titov et al. 2013 |
| Population | See Titov et al. 2013 |
**Key outcomes**

Significant improvements in symptoms of anxiety and depression were observed over time in both treatment groups (TEG and TG). These were sustained from post-treatment to 12-month follow up (ps>.05) and were associated with large effect sizes.

No statistically significantly differences in symptoms were found between the TEG and TG groups at post-treatment, 3-month or 12-month follow up. Previously reported symptom differences between TEG and TG group participants with comorbid (anxiety and depression) symptoms were no longer present at 12-month follow up.

**Recently completed and ongoing studies**

The technology owner said there are a number of ongoing evaluations on the use of the Wellbeing Course for people with depression. Several of these are trials, mainly looking at mechanisms of change.

**Economic evidence**

One published economic study on the Wellbeing Course was identified. This was carried out in Australia. Lee et al. (2017) did an economic evaluation on the cost effectiveness of the Wellbeing Course compared with routine or usual care in people with depression, anxiety or both, who were seeking treatment. In terms of efficacy, routine or usual care was assumed to be a mixture of the Wellbeing Course and no treatment (waiting list). In terms of resource use, routine or usual care comprised medication with or without psychological therapy, based on healthcare resource use data obtained from a national survey of mental health and wellbeing. The study concluded that the Wellbeing Course cost less and had more benefits than usual care. The authors acknowledged that the course needs to be compared with a prospective matched comparator to verify their findings.
Cost and resource impact

Technology costs

The Wellbeing Course is not yet in use in the UK, but the technology owner estimates that the cost to the NHS of using this technology would be around £39 per user (including VAT) based on a licence cost of between £25 and £40 (excluding VAT). Including 90 minutes of a PWP’s time, the total cost will be around £70 per person.

There will be an additional one-off cost for therapists and administrators to access the online training. This is still under development and costs and price structures are not yet defined.

Resource impact compared with standard care

Table 5 Cost of the Wellbeing Course per person compared with existing treatment options for GAD

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Existing cost</th>
<th>Cost using the Wellbeing Course</th>
<th>Cost/saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guided self-help</td>
<td>£63</td>
<td>£70</td>
<td>£7 cost</td>
</tr>
<tr>
<td>Group CBT</td>
<td>£102</td>
<td>£70</td>
<td>£32 saving</td>
</tr>
<tr>
<td>Workshop CBT</td>
<td>£8</td>
<td>£70</td>
<td>£62 cost</td>
</tr>
<tr>
<td>CBT for depression</td>
<td>£608</td>
<td>£70</td>
<td>£538 saving</td>
</tr>
<tr>
<td>Course of selective serotonin reuptake inhibitor (SSRI)</td>
<td>£75</td>
<td>£70</td>
<td>£5 saving</td>
</tr>
</tbody>
</table>

The following costing assumptions have been made:

- The Wellbeing Course is expected to cost around £70 per person (including VAT).
- The Wellbeing Course may be delivered by a PWP; costs include 90 minutes of their time per person receiving treatment.

Overall impact

Using the new technology is unlikely to save costs directly, but it may free staff time to deal with more dependent people. For example, a reduction in individual guided self-help is expected to release therapist time.
Early interventions and home treatment for mental health problems can reduce hospital admissions, shorten hospital stays and require fewer high-cost intensive interventions. This may create more capacity and access for people requiring urgent mental health services.

Early treatment of people with mental health problems may help people to continue to work or return to work more quickly after a mental health problem.

**Cost and resource impact statement from the technology owner**

The technology owner states that the Wellbeing Course will reduce the amount of therapist time needed to support people with depression.

There will be an element of training needed for PWPs to support people using the Wellbeing Course. The technology owner has not yet confirmed how much training will cost.

**IAPT expert panel considerations**

The expert panel considered the assessments of therapeutic content, digital technological factors, clinical and economic evidence and resource impact in making their decision that the Wellbeing Course for depression should not progress to the evaluation in practice stage of the NICE and NHS England IAPT assessment programme.

The panel concluded that the technology is not suitable for use in IAPT services because of the failed technical assessment.

The panel noted that the use of a transdiagnostic approach resulted in the programme not covering all the elements that would be expected to be included in a course focused on treating depression in IAPT services.

**Technical assessment**

The panel considered the outcome of the technical assessment. They noted the areas of concern identified in the initial assessment and the technical assessors’ conclusions on the remediation actions suggested. They agreed
that the responses in the interoperability and technical stability domains remained insufficient to pass the assessment. They also noted the comprehensive remediation plan in the clinical safety and data protection domain would require a 6-month implementation period. As such, the panel concluded the Wellbeing Course is not suitable for the evaluation in practice phase of the NICE and NHS England IAPT assessment programme.

**Content assessment**

The panel discussed the content assessment and agreed with the assessors’ conclusion that the transdiagnostic approach used does not cover all the elements that would be expected to be included in a course focused on depression.

The panel noted that the technology is well designed and easy to use.

The panel agreed that the lessons, delivered as slide sets, were rather lengthy and do not take advantage of opportunities for interactive learning and teaching.

**Clinical evidence**

The panel considered the main points from the evidence from 3 randomised controlled trials and noted their strengths and limitations. In all studies there were significant reductions in symptoms of depression after the Wellbeing Course. Between group effect sizes varied from small to large.

The panel noted that none of the studies compared the Wellbeing Course with face-to-face CBT.

**Economic evidence**

The panel discussed the economic evidence for the technology where the comparator was routine or usual care.

**Cost and resource impact**

The panel noted the cost and resource impact assessment.
The panel discussed the model for 3 days training for therapists to use the course in Australia, which could be a barrier to its use in IAPT services in England. They also noted that online training is still in development and the cost unknown.

Development of this briefing

This briefing was developed by NICE for NHS England’s assessment of digitally enabled psychological therapies for IAPT. The briefing was presented to NICE’s IAPT expert panel, who considered the Wellbeing Course for depression for this assessment programme. The process and methods statement sets out the process for selecting topics, and how the briefings are developed, quality-assured and approved for publication.

Panel members

- Professor Tim Kendall (chair), National Clinical Director for Mental Health, NHS England and NHS Improvement
- Ms Lauren Aylott, lay member
- Professor Peter Bower, Professor of Health Services Research, Manchester University
- Professor Chris Hollis, Professor of Child and Adolescent Psychiatry, University of Nottingham
- Dr Ifigeneia Mavranezouli, Senior Health Economist, University College London
- Ms Toni Mank, Clinical Director for Planned and Scheduled Care and Head of IAPT, Sheffield Health and Social Care NHS Foundation Trust
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- Professor Steve Pilling, Professor of Clinical Psychology and Clinical Effectiveness, University College London
- Dr Georgina Ruddle, Acting Associate Director Mental Health, Maternity and Children, and Interim Transforming Care Partnerships Lead, NHS Wiltshire Clinical Commissioning Group
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