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Clinical Decision Making Tool
in Low Intensity CBT

Please Note: This tool has been produced to give an overview of where there is current evidence to work at Step 2 and what treatments may offer the best **primary intervention to offer first**. The recommended option within a stepped care model should be the least restrictive of those currently available, but still likely to provide significant gain in improvement of the presenting problem for the person. This tool is based on the least restrictive and burdensome principles as well as providing information about treatment step-up options at Step 3 that should be carried out only by trained and accredited practitioners in that modality. Individual services may have their own individual protocol of what disorders and levels of severity are seen at Step 2 depending upon if they operate a pure or stratified service model of stepped care, therefore please always consult your own service protocols and use case management and clinical skills supervision to make clinical decisions within your own area. Although NICE recommends some step 2 interventions for some disorders this may fall beyond the remit of the national PWP curricula (e.g. OCD, Bulimia etc.), therefore these interventions should only be used if you have received specific training in their use, have your supervisor agreement for your treatment plan and feel that you are working within the boundaries and limitations of your own competency at all times.

Disorder	LICBT Step 2 primary treatment	Delivery formats recommended	Alternative Treatment Option(s) at Step 2	Step up treatment options
Depression	• Behavioural Activation (LICBT protocol)	1:1, Telephone, Face to face, Interactive supported Group (groups limited evidence to date)	• Physical Activity Programme • Practical Problem Solving • cCBT - be aware of evidence e.g. REEACT trial, Gilbody, 2015 that supported cCBT for depression does not improve symptoms above with routine GP care • Cognitive	• Cognitive Behavioural Psychotherapy (Beck) • BA (Martell model) • Interpersonal Therapy • 10 sessions of counselling for depression • Brief Dynamic Interpersonal Therapy • Behavioural Couples counselling

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			restructuring	
Panic Disorder with/without agoraphobia	• Exposure and Habituation (LICBT protocol)	1:1, Telephone, Face to face, Interactive Supported Group.	• Cognitive restructuring • cCBT	• Cognitive Behavioural Psychotherapy (Clark or Barlow models)
Generalised Anxiety Disorder	• Managing worry: followed as a protocol (worry classification, worry time, problem solving, PGMR)	1:1, Telephone, Face to face, Interactive Supported Group (must be specific to GAD), didactic unsupported classes.	• Practical Problem Solving	• Cognitive Behavioural Psychotherapy (Borkovec, Dugas/Ladouceur or Zinbarg/Craske/Barlow)
Specific Phobia	• Exposure and response prevention	1:1, Telephone, Face to face.	• n/a	• Cognitive Behavioural Psychotherapy (Butler, G or Craske/Antony/Barlow)
OCD	• Exposure and Response Prevention Self Help for mild presentation (mild = OCD occupies up to 1 hour per day of intrusions undertaking compulsions)	1:1, Telephone, Face to face, Group	• n/a	• Cognitive Behavioural Psychotherapy using ERP (Steketee/Kozac /Foa)

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PTSD	• No evidence based current step 2 interventions. Patients should step up	n/a	• n/a	• Cognitive Behavioural Psychotherapy Trauma focused CBT (Foa and Rothbaum, Resick or Ehlers) • EMDR
Bulimia/ Binge Eating Disorder	• Evidence based CBT guided self help	cCBT, 1:1, Face to face (not group),	• n/a	• Cognitive Behavioural Psychotherapy for bulimia nervosa (CBT-BN) • Cognitive Behavioural Psychotherapy for Binge Eating Disorder (CBT-BED) • Interpersonal psychotherapy (IPT) but the patient should be informed results will take longer than with CBT • Modified dialectical behaviour therapy for BED.
Anorexia	• No current step 2 interventions. Patients should step up	n/a	n/a	• Cognitive analytic therapy (CAT) • Cognitive behaviour therapy (CBT) • Interpersonal psychotherapy (IPT) • Family therapy and family interventions • Focal Psychodynamic psychotherapy
Social Anxiety Disorder	• CBT-based supported self-help **only** if full CBT is declined by patient	1:1, Telephone, Face to face (not group)	n/a	• Cognitive Behavioural Psychotherapy (Clark & Wells model or Heimberg) • Short-term psychodynamic psychotherapy
Illness Anxiety Disorder	• No current NICE Guideline to inform treatment. Service decision until guidance provides definitive answer. Limited evidence based self help options and complexity	n/a	n/a	• No current NICE guidelines to inform treatment and not in Roth & Pilling competenices. Cognitive Behavioural Psychotherapy is the evidence based treatment option.

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	of treatment means patients should be discussed at supervision and stepped up			

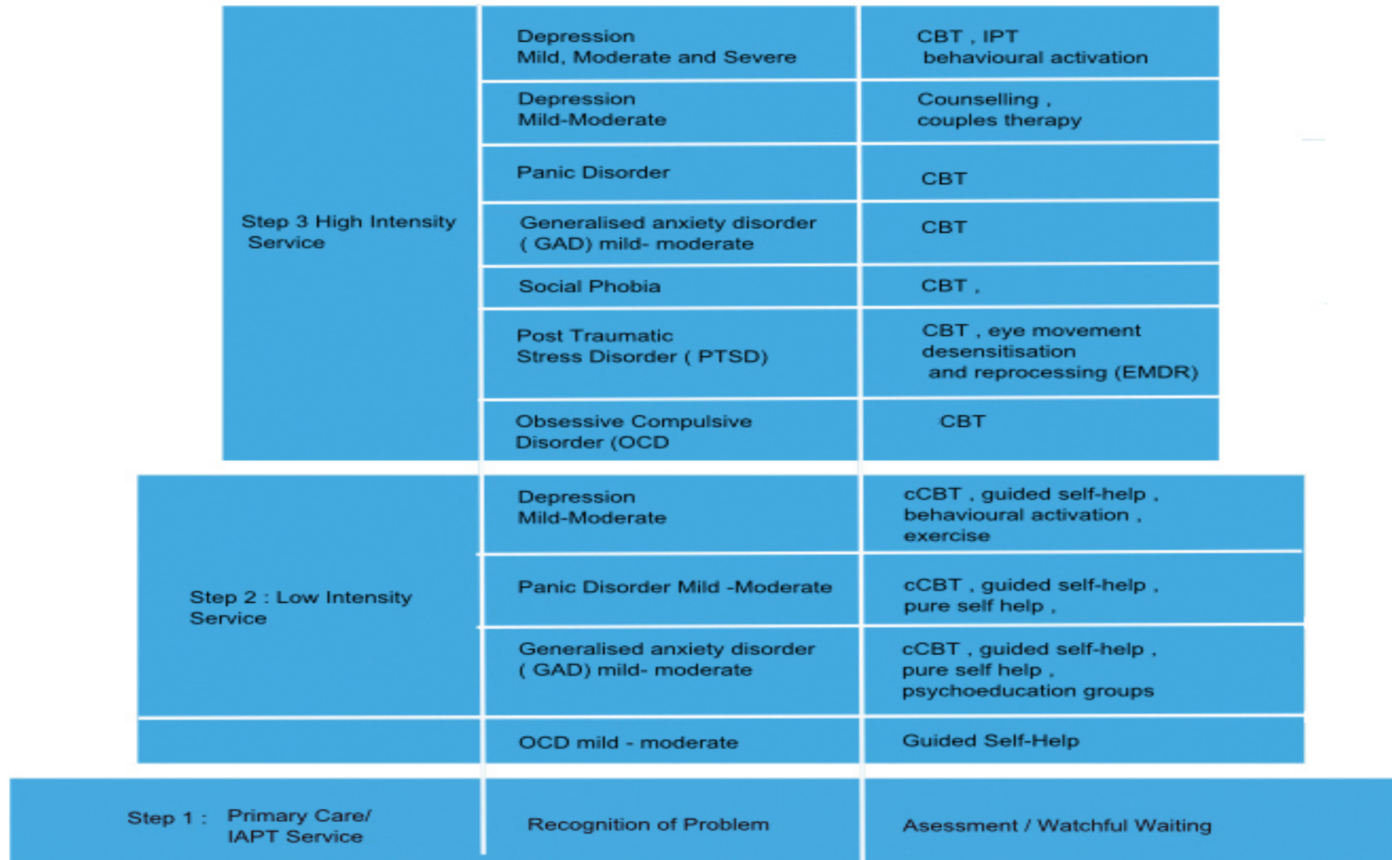

Figure 1. IAPT Stepped care model, 2011.

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