

BMHP6029

**Psychopathological Classifications
and Provisions**

Week 4

**Mental Health Support Services,
Depression,
Generalised Anxiety Disorder**

2026





Structural

- UK MH service structure
- Critically appraise Depression & GAD diagnosis/treatment
- Understand inequalities & access

Do we need
mental health
services?



Why mental health services matter



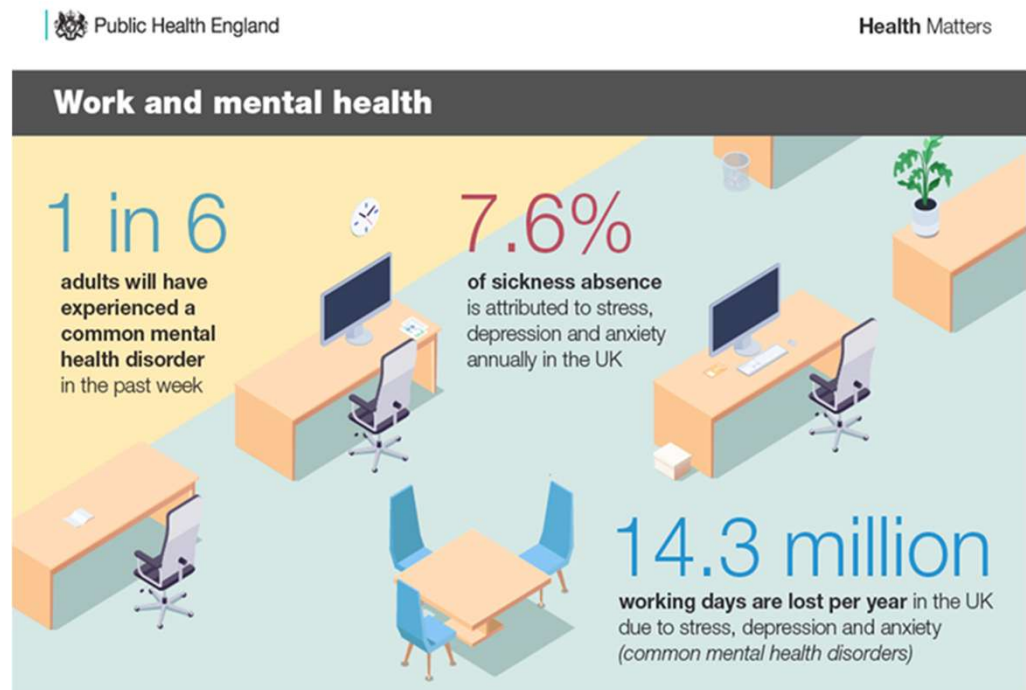
Poor MH impacts productivity and employment



Demand rose post-pandemic; complexity & waits increased



Integrated, prevention-focused services improve outcomes



[Health matters: health and work - GOV.UK \(www.gov.uk\)](https://www.gov.uk/health-matters/health-and-work)

Understanding Mental Health Services in the UK

- [Mental health - NHS \(www.nhs.uk\)](http://www.nhs.uk)



Policy snapshot 2016→2026

- [Post-2010 Reforms: Introduction of the “No Health Without Mental Health” strategy in 2011¹](#).
- 2016: Five Year Forward View & Mental Health Taskforce
- 2023: TTAD rebrand and continued outcome monitoring
- 2025: Mental Health Act receives Royal Assent (rights, detention criteria)
- 2025: 10-Year Health Plan—workforce, MH emergency departments, prevention

Mental Health Bill 2025

“modernise mental health legislation to give patients greater choice, autonomy, enhanced rights and support, and ensure everyone is treated with dignity and respect throughout treatment.

This legislation is intended to give effect to the policy approaches outlined in Sir Simon Wessely’s landmark [Independent Review](#) in 2018.

These were subsequently taken forward in the previous government’s white paper [Reforming the Mental Health Act](#) in 2021.

These measures aim to give people greater control over their treatment and help ensure they receive the dignity and respect they deserve.”

Evolution of Strategies and Priorities

- **Integrated Care:** Emphasis on integrating physical and mental health care.
- **Prevention Initiatives:** Focus on early intervention and prevention of mental health issues.
- **Funding and Investment:** Significant new investments to support mental health services.
- **Patient Safety:** Enhanced focus on patient safety and data collection in mental health settings.
- **Challenging Stigma:** Efforts to reduce stigma associated with mental health.

What has changed?



Vastly improved access to talking therapies through training of new staff. Stigma has reduced as a result (?)



Mental health now given the same priority as physical health.



Ongoing efforts to further improve quality and access.

Range of Mental Health Services in the UK



Aims to place service users at the least intrusive, least intensive service level, and most appropriate for their current needs.

Primary Care mental health services

- The NHS Talking Therapies for Anxiety and Depression programme (TTAD), formerly “Improving Access to Psychological Therapies” (IAPT), was launched in 2008 to improve the quality and accessibility of mental health services in England.
- TTAD focuses on ‘talking therapies’ like Cognitive Behaviour Therapy, Counselling and self-help support including ‘digital therapy’.
- For working-age people experiencing common mental health problems such as anxiety and depression.
- People can be referred to TTAD either through their GP or they can self-refer by phone or online.

primary care psychological therapies services

NHS Talking Therapies, for anxiety and depression services have three key principles:

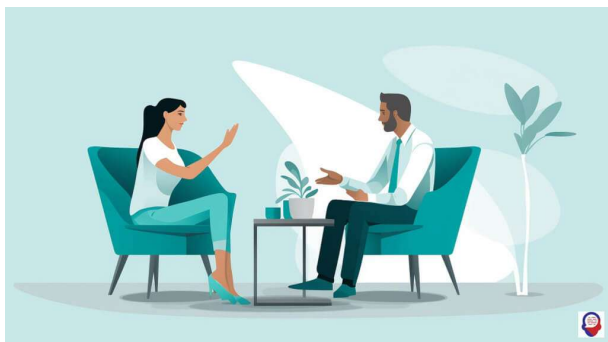
1. All psychological therapies offered are evidence-based (recommended by NICE) and are matched to the mental health problem (diagnosis), and the intensity and duration of treatment optimises outcomes.
2. All clinical staff are appropriately trained to provide high quality care and supervised by senior clinical practitioners who support continual improvement.
3. Routine outcome monitoring via standardised measures is used on a session-by-session basis, so that the person having therapy and the clinician offering it have up-to-date information on the person's progress (evidence based). The outcomes of all NHS Talking Therapies, for anxiety and depression services are published by NHSdigital.

Services are delivered using a stepped-care model, which works according to the principle that people should be offered the least intrusive intervention appropriate for their needs first.

NHS Talking Therapies (TTAD)

Principles

- Evidence-based therapies at appropriate dose
- Workforce training & supervision
- Session-by-session outcome monitoring; transparent data



<https://counselling-uk.com/psycho-therapy/cbt-stand-for/>

TTAD outcomes (England, 2023/24)



Referrals: 1.83 million (+4% YoY)



Waits: 90.5% started treatment within 6 weeks



Recovery: 50.1%; Avg. 8.2 sessions



Internet-enabled therapy sessions declined vs 22/23

NHS Talking Therapies, for anxiety and depression services offer therapy for people with the following common mental health problems:

depression

generalised anxiety disorder (GAD)

health anxiety

mixed depression and anxiety

obsessive-compulsive disorder (OCD)

panic disorder

Post-traumatic Stress Disorder (PTSD)

social anxiety disorder

agoraphobia

body dysmorphic disorder (BDD)

specific phobias (such as heights, flying, spiders).

What are talking therapies?

Talking therapies are provided in different ways, including:



using a self-help workbook or online content with the support of a therapist



one-to-one in person, by phone, or via video such as MSTeams.



in a group.

**Types of therapy offered
in NHS Talking Therapies
for anxiety and
depression services**





Local access: Birmingham & Solihull

- Birmingham Healthy Minds: self-referral (phone/online); phone/video/in-person; groups/workshops
 - Coventry/Warwickshire/Solihull Talking Therapies: digital assistant, online form, phone
 - NHS.uk Talking Therapies finder for other areas
-



Challenges & inequalities (2024/25→2026)

Rising demand; long
waits; complexity
managed in
community

Workforce burnout;
commissioning
variation by ICS

Inequalities by
deprivation/ethnicity;
women ≈66% of TTAD
referrals

Improving Access and better outcomes?

Secondary Care

- Access to and contact with mental health services varies across the country. The highest was Hull, where 10.8% of the adult population were in contact with mental health services during 2022/23. The lowest was Mid Essex (3.6%).

Primary Care

- Recovery and improvement rates varied between social groups, with some minority groups less likely to see positive outcomes:
- People living in more deprived areas were less likely to experience improvement or recovery after TTAD than those living in less deprived areas
- People with disabilities were less likely to experience improvement or recovery than those without disabilities
- People identifying as bisexual were less likely to experience improvement after TTAD than people identifying as straight
- People in Bangladeshi, Pakistani, Mixed and Other Ethnic Groups were less likely to experience improvement and recovery after TTAD than those identifying as White British, Indian, African or Caribbean.

Challenges within the system

Access to services – inequalities, service barriers such as wait times and provision of treatments, regional differences

Shortages of trained staff

Evidence-based services need good quality evidence to improve. How do we assess what 'good outcome' means?

Money

Impact of the Covid19 pandemic

Demand for mental health services grows every year.



Depression

Depression: diagnosis (ICD-11 & DSM-5)

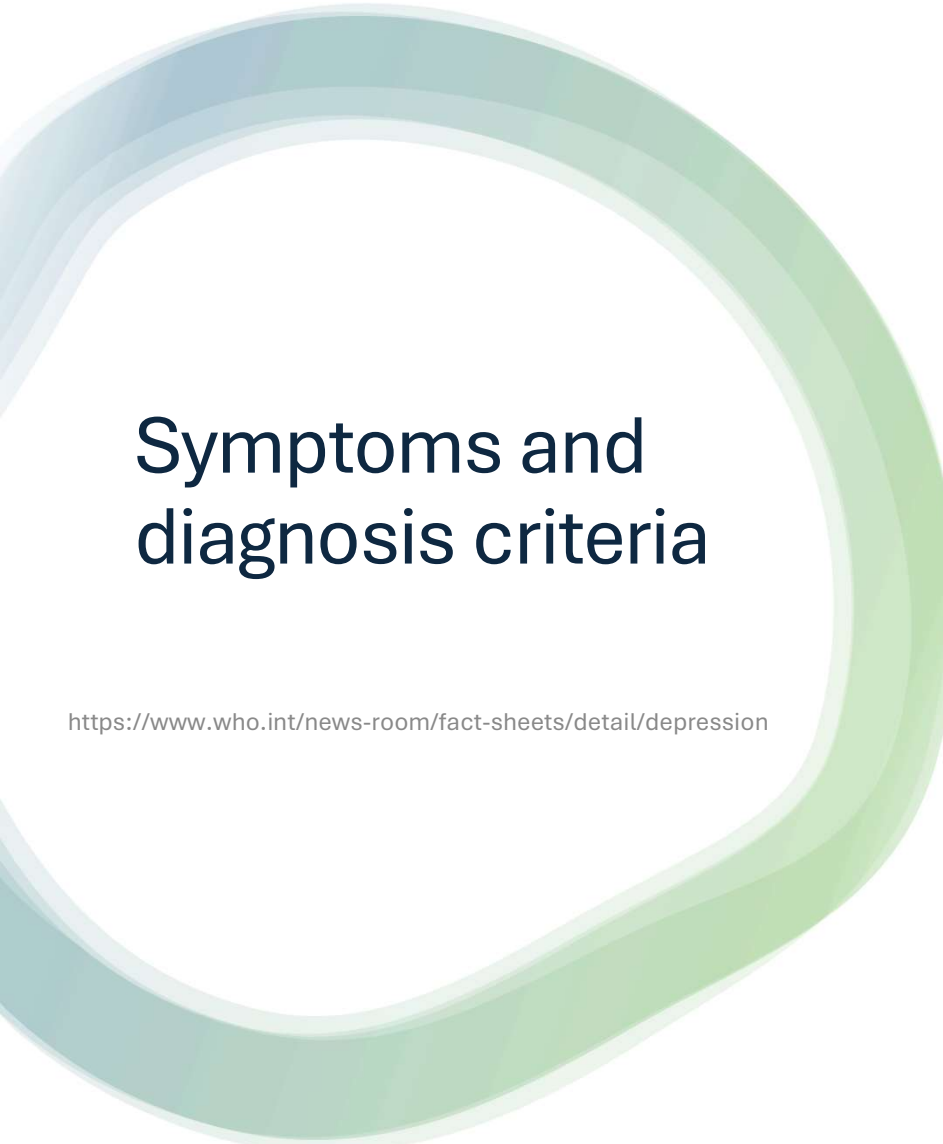
Core: depressed mood/anhedonia ≥ 2 weeks, most of day, nearly every day

Functional impairment; associated symptoms (sleep, appetite, energy, concentration, guilt)

DSM-5: ≥ 5 symptoms including mood or anhedonia

Depression





Symptoms and diagnosis criteria

<https://www.who.int/news-room/fact-sheets/detail/depression>

ICD-11

- Depression is defined as the presence of depressed mood or diminished interest in activities occurring most of the day, nearly every day, for at least 2 weeks, accompanied by other symptoms such as:
 - Reduced ability to concentrate and sustain attention or marked indecisiveness
 - beliefs of low self-worth or excessive or inappropriate guilt
 - hopelessness about the future
 - recurrent thoughts of death or suicidal ideation or evidence of attempted suicide
 - significantly disrupted sleep or excessive sleep
 - significant changes in appetite or weight
 - psychomotor agitation or retardation
 - reduced energy or fatigue

DSM-5

- Depression is defined as the presence of 5 or more symptoms from a list of 9 symptoms, during the same 2-week period and where at least 1 of the symptoms is depressed mood or loss of interest or pleasure, most of the day, nearly every day. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

NICE recommendation to GPs:

- Be alert to possible [depression](#) (particularly in people with a past history of depression or a chronic physical health problem with associated functional impairment) and consider asking people who may have depression if:
- During the last month, have they often been bothered by feeling down, depressed or hopeless?
- During the last month, have they often been bothered by having little interest or pleasure in doing things?

NICE (2022)

Global Impact of Depression

- In 2019, an estimated 280 million people, including 5% of all adults, experienced depression. Depression is more common among women than men. Worldwide, more than 10% of pregnant women and women who have just given birth experience depression.
- Depression can cause difficulties in all aspects of life, including performance at school, productivity at work, relationships with family, friends and community.
- Researchers estimate that 12 billion productive work days are lost every year to depression and anxiety alone, at a cost of nearly US\$ 1 trillion.
- People with depression are at increased risk of suicide. Research also shows strong relationships between depression and physical health, including cardiovascular disease, cancer, diabetes and respiratory diseases (WHO, 2024)

Symptoms and diagnosis criteria

Depression severity exists along a continuum and is essentially composed of 3 elements:

- symptoms (which may vary in frequency and intensity)
- duration of the disorder
- the impact on personal and social functioning

Severity of depression is therefore a consequence of the contribution of all of these elements.



What is Depression?

Depressive disorder, or depression, is a common mental health condition that can happen to anyone. It is characterized by a low mood or loss of pleasure or interest in activities for long periods of time.



This is different from regular mood changes and feelings about everyday life. Depressive episodes last most of the day, nearly every day, for at least two weeks. People with depression may experience disturbed sleep and changes to their appetite. They may have feelings of low self-worth, thoughts about dying and hopelessness about the future. Tiredness and poor concentration are also common.



People who have lived through abuse, severe losses or other adverse events are more likely to develop depression. Problems at school and work can also result in depression.



Prevention programmes have been shown to reduce depression. There are also effective psychological treatments and medications for depression. However, these are often absent or inaccessible, especially in low- and middle-income countries. It is estimated that more than 75% of people experiencing mental disorders in low- and middle-income countries receive no treatment.



WHAT IS DEPRESSION?



Causes of Depression

“...genetic and epigenetic factors, environmental conditions, various stresses, deficiency in some nutrients to which people are exposed, as well as childhood abuse, and by the classic twin design, the researchers found that the effect of genetic and environmental impactions are involved in almost all psychological features” (Alshaya, 2022, p. 2)



Models of Depression

Several psychological theories explain depression. Here are some of the main ones:

Behaviourist Theory:

- **Classical Conditioning:** Depression is learned through associating certain stimuli with negative emotional states.
- **Operant Conditioning:** Depression is caused by the removal of positive reinforcement from the environment. For example, losing a job can reduce positive reinforcement from others, leading to depression

Cognitive Theory:

- **Beck's Cognitive Theory:** Aaron Beck proposed that depression is caused by negative thoughts and cognitive distortions. Individuals with depression tend to have a negative view of themselves, the world, and the future.
- **Learned Helplessness:** Martin Seligman suggested that depression results from a perceived lack of control over the outcome of situations. This leads to feelings of helplessness and hopelessness.

These are the foundations of CBT – the 'B' and the 'C'

Other models of depression



Psychodynamic Theory:

Freud's Theory: Sigmund Freud believed that depression is caused by unresolved conflicts and unconscious processes from early childhood experiences. Depression is seen as anger turned inward.

Object Relations Theory: This theory focuses on the impact of early relationships with caregivers on the development of depression. Loss or rejection by a caregiver can lead to feelings of worthlessness and depression.



Humanistic Theory:

Maslow's Hierarchy of Needs: Abraham Maslow suggested that depression occurs when individuals are unable to meet their basic needs and achieve self-actualization.

Rogers' Person-Centered Theory: Carl Rogers believed that depression results from a discrepancy between an individual's self-concept and their ideal self.



Biopsychosocial Model:

This model integrates biological, psychological, and social factors in understanding depression. It recognizes that depression is influenced by genetic predisposition, brain chemistry, personality traits, and environmental stressors.

Depression: evidence-based treatments (NICE NG222)

Less severe: BA/CBT, Counselling; consider IPT

More severe: CBT, IPT, pharmacotherapy combinations

Couples therapy for Depression (when relationship factors salient)

MBCT for relapse prevention

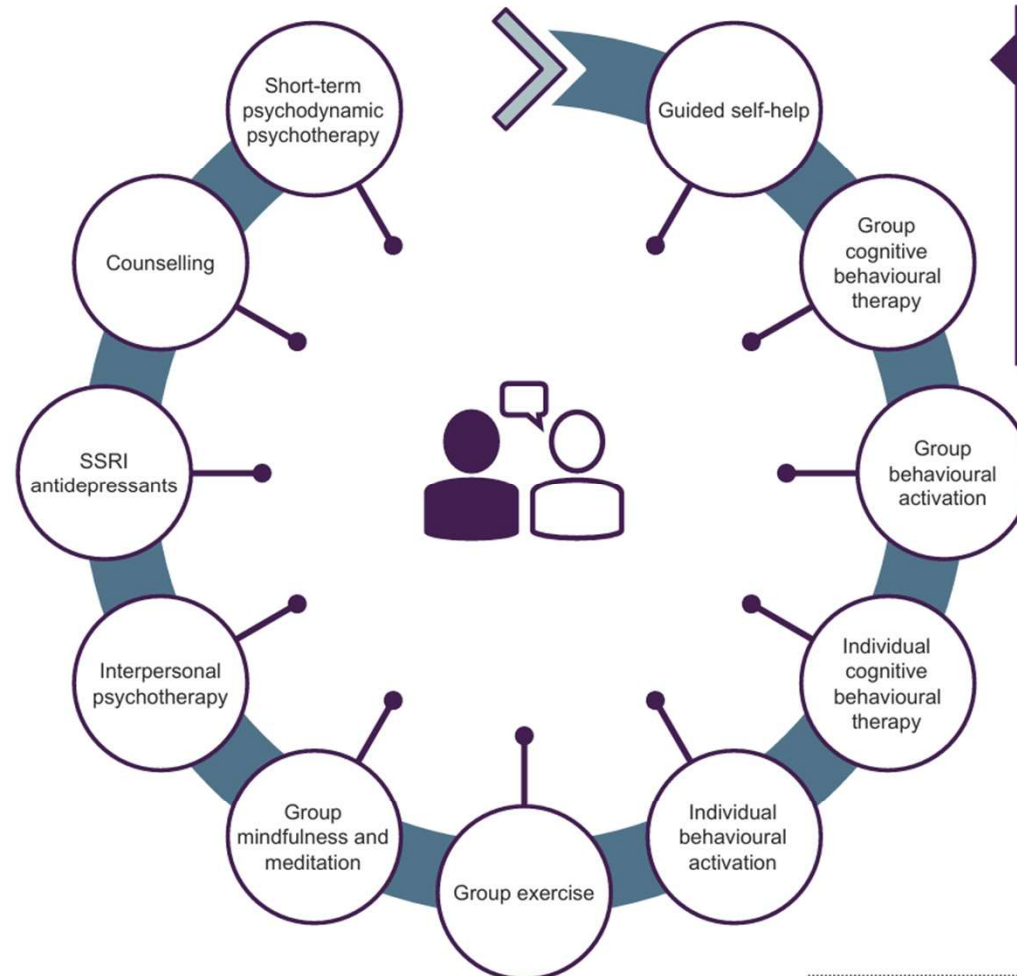
Consider rTMS/ECT for treatment-resistant/severe

Depression in adults: discussing first-line treatments for less severe depression

Discuss treatment options and match the choice of treatment to clinical needs and preferences, taking into account that any option can be used as first line, but consider the least intrusive and least resource intensive treatment first (guided self-help).

If the person has a clear preference, or experience from previous treatment to use as a guide: support the person's choice, unless there are concerns about suitability for this episode of depression.

Do not routinely offer antidepressants as a first-line treatment, unless that is the person's preference.



Treatment options are listed in order of recommended use, based on the committee's interpretation of their clinical and cost effectiveness and consideration of implementation factors.

Why is depression on the increase?

- Download to read the article from the online reading list.

Santomauro, D.F., Mantilla Herrera, A.M., et al (2021). Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic. The Lancet.



Discuss why is the prevalence of depression increasing.

Is the diagnosis of depression a cultural phenomenon?

What does the latest research say about how to prevent rates of depression from increasing?

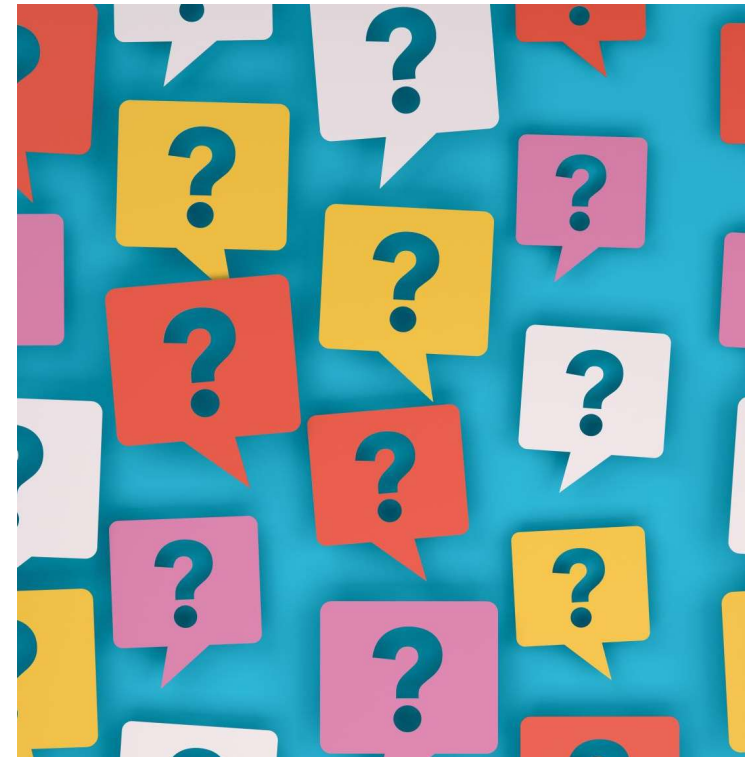


Generalised Anxiety Disorder

“GAD”

What is Generalised Anxiety Disorder (GAD) ?

- GAD is a general, long-lasting worry and anxiety about everyday life, about anything and everything.
- People experiencing GAD imagine the worst happening (and worry about all the possible worst case scenarios).
- They also believe they won't be able to cope when these possible imagined terrible things 'do' happen.
- However, as in all anxiety, we tend to over-estimate the danger, and under-estimate our ability to cope.





GAD: ICD-11 diagnostic essentials

- Persistent, excessive apprehensiveness/worry across domains
- Somatic/autonomic symptoms (tension, sleep disturbance, palpitations)
- Duration: several months; distress/impairment
- Rule-outs: substances, medical conditions, other disorders

GENERALIZED ANXIETY DISORDER



The ICD-11 diagnostic criteria for GAD include:

- Marked symptoms of anxiety manifested by either general apprehensiveness that is not restricted to any particular environmental circumstance, or excessive worry about negative events occurring in several different aspects of everyday life.
- Anxiety and general apprehensiveness or worry accompanied by additional symptoms, such as: muscle tension or motor restlessness; sympathetic autonomic overactivity (for example, frequent gastrointestinal symptoms, palpitations, sweating, trembling, shaking, and/or dry mouth); subjective experience of nervousness, restlessness, or being 'on edge'; difficulty concentrating; irritability; sleep disturbances (difficulty falling or staying asleep, or restless, unsatisfying sleep).
- The symptoms are not transient and persist for at least several months, for more days than not; are not better accounted for by another mental disorder; are not a manifestation of another medical condition and are not due to the effects of a substance or medication on the central nervous system.
- The symptoms result in significant distress about experiencing persistent anxiety symptoms or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Models of GAD

Several psychological theories explain Generalised Anxiety Disorder (GAD). Here are some of the main ones which inform CBT in the UK

1.Cognitive Avoidance Theory:

- This theory suggests that individuals with GAD use worry as a cognitive strategy to avoid distressing mental images and emotional arousal. By worrying, they attempt to prevent negative outcomes and reduce their anxiety, but this strategy ultimately maintains their anxiety.

2.Metacognitive Model:

- Proposed by Wells (1995), this model suggests that people with GAD hold both positive and negative beliefs about worry. Positive beliefs lead them to see worry as a helpful strategy, while negative beliefs cause them to view their worry as uncontrollable and dangerous, leading to further anxiety.

3.Intolerance of Uncertainty Theory:

- This theory, developed by Dugas et al. (2007), suggests that individuals with GAD have a heightened intolerance of uncertainty. They find uncertain situations distressing and engage in worry as a way to gain a sense of control and predictability.

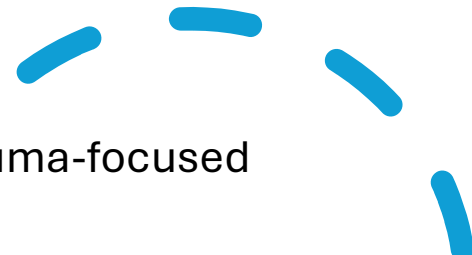


GAD: maintaining mechanisms (CBT-relevant)

- Intolerance of Uncertainty (Dugas): worry to seek predictability
- Metacognitive model (Wells): beliefs about worry (helpful vs uncontrollable)
- Cognitive avoidance: verbal worry suppresses imagery/emotion



PTSD & EMDR (NICE NG116)

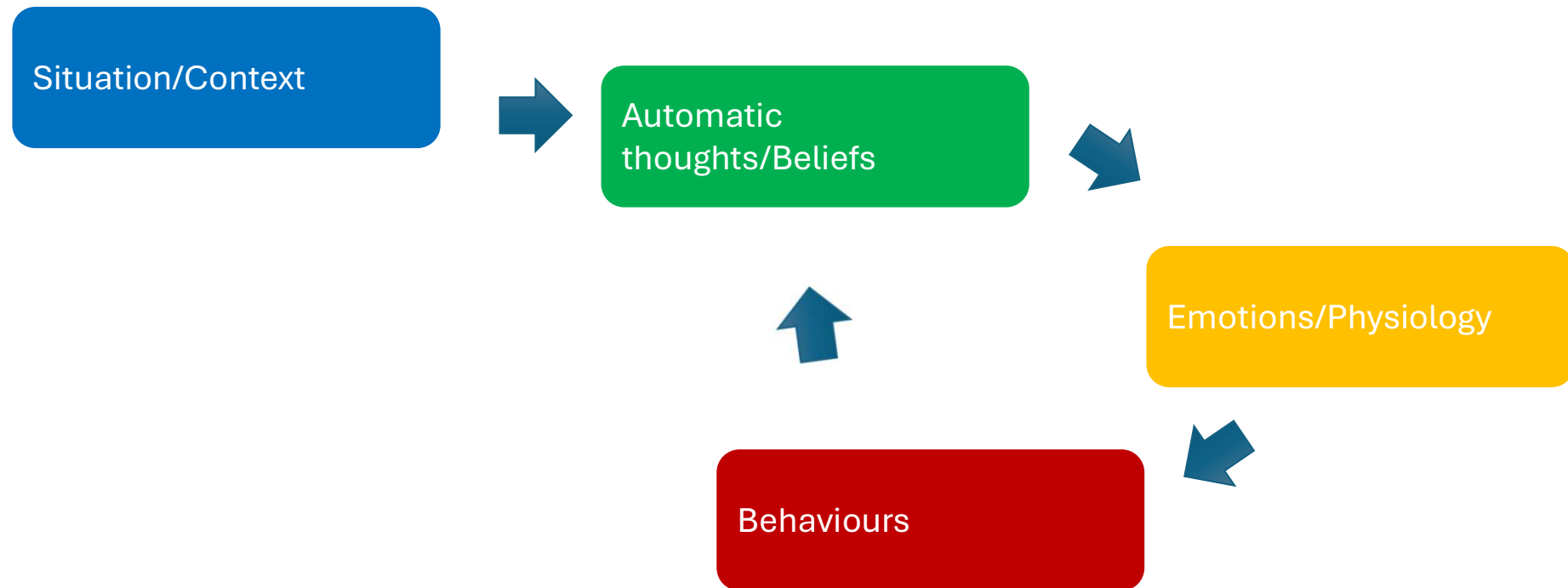
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- EMDR is indicated for PTSD/trauma-focused treatment
 - Not first-line for GAD or non-trauma depression
 - Trauma screening is essential in assessment

What is CBT?

WHAT WE THINK AND DO
AFFECTS THE WAY WE FEEL
& HOW WE FEEL AFFECTS
WHAT WE THINK AND DO.



CBT cycle: how problems are maintained





**Doctor explains Cognitive Behavioural Therapy (CBT)
What it is, who it helps, how it works.**



BELIEFS THAT SUPPORT CHRONIC WORRY

-PERFECTIONISM

-OVER-RESPONSIBILITY

-DEMAND FOR CONTROL

CBT for GAD

The CBT model



The CBT model proposes that it is not the situation that causes the emotional distress that an individual experiences. Rather, it is the individual's interpretation or view of that event or situation which causes the emotional distress.



Key therapeutic principles underpinning CBT:



Therapy is regarded as a collaborative project between client and therapist



The work is problem-focused and structured



Aims to help the client become their own therapist



CBT helps to break the cycle of negative thinking and behaviour that can keep depression or anxiety going. A CBT therapist teaches skills to manage your thoughts and feelings, leading to positive changes in how you feel and overall well-being.

CBT: techniques & planning



- Behavioural Activation (activity scheduling, values, graded tasks)
- Cognitive restructuring (Socratic questions, evidence testing)
- Exposure & behavioural experiments (for worry/anxiety)
- Relapse prevention (blueprint, early-warning signs, coping plans)

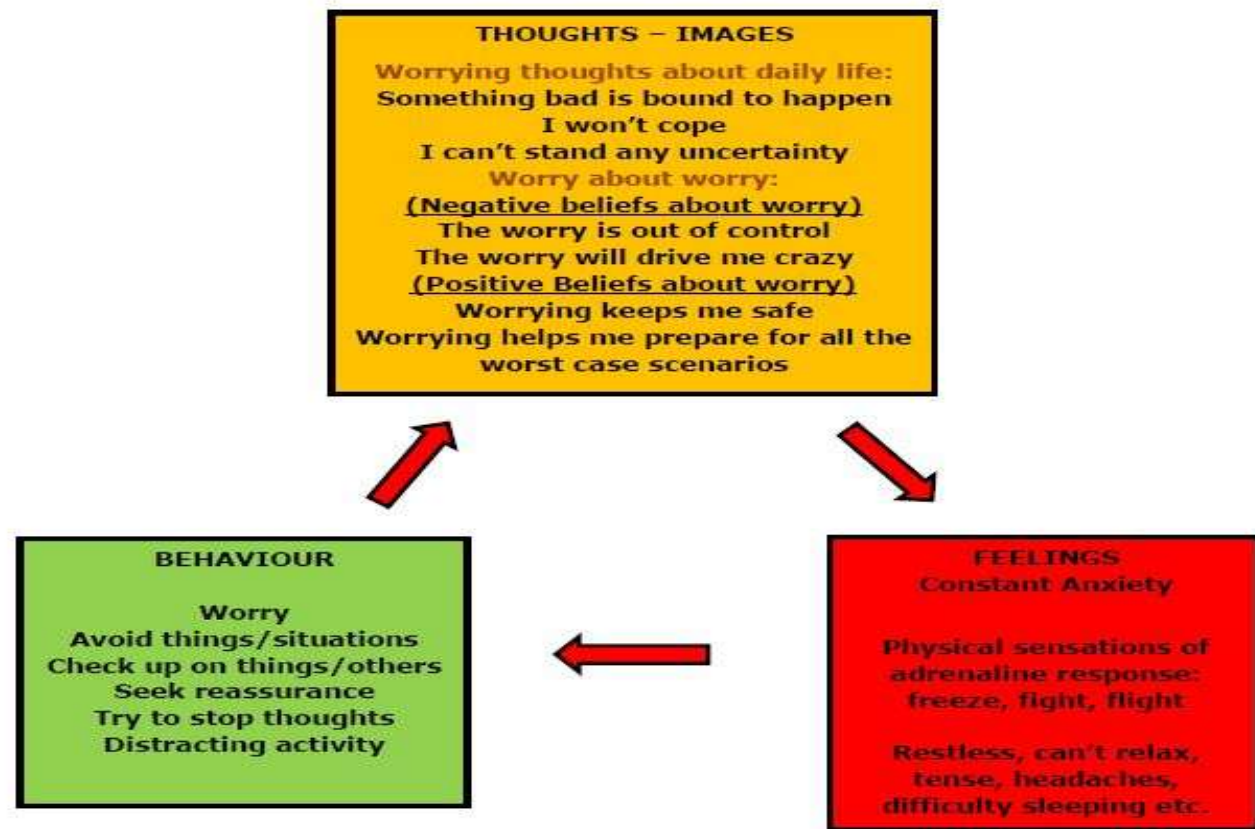
Here's how a simple CBT formulation can lead to therapeutic change in depression:

- 1. Identify unhelpful Thoughts:** The first step is to identify the negative thoughts that are making the person feel depressed. For example, "I'm not good enough" or "Nothing ever goes right for me."
- 2. Challenge unhelpful Thoughts:** Once client and therapist have identified these negative thoughts, the next step is to challenge them by considering evidence. Questions like, "Is this thought always true?" or "What evidence do I have that this thought is accurate?"
- 3. Replace with more realistic Thoughts:** After challenging the negative thoughts, replace them with more positive or realistic thoughts. For example, instead of thinking "I'm not good enough," you might think, "I have strengths and weaknesses, just like everyone else."
- 4. Change Behaviors:** CBT also focuses on changing behaviours that contribute to depression. For example, if a person tends to isolate themselves when feeling down, CBT might encourage them to engage in activities that they find meaningful or spend time with supportive friends and family.
- 5. Practice and Repeat:** Finally, it's important to practice these new ways of thinking and behaving regularly. Like learning a new skill such as playing a musical instrument or studying. Over time, this can help to reduce symptoms of depression and improve the person's overall mood.

An example of a 'vicious cycle' for a client who has begun CBT. How the client feels is being maintained by both the client's thoughts and actions.



An example of a vicious cycle of GAD



Courtesy of Get.gg, www.get.gg

Treating Anxiety Disorders

Dr Paul Salkovskis Bath University



Case study A: Moderate Depression (working-age adult)

- Context: recent job stress; sleep disturbance; reduced social contact
- PHQ-9=17; GAD-7=9; values: family, competence
- Formulation: loss of positive reinforcement → reduced activity → low mood
- Plan: BA (3 activities/week), cognitive testing of 'I'm failing', sleep hygiene, relapse plan

Case study B: GAD (intolerance of uncertainty)

- Context: persistent worry about finances/health despite no acute triggers
- GAD-7=15; beliefs: 'If I don't worry, I'll be unprepared'
- Formulation: IU + positive/negative metacognitive beliefs → worry/avoidance
- Plan: psychoeducation, worry scheduling, behavioural experiments, IU training

Measuring change & outcomes

- Session-by-session measures (PHQ-9, GAD-7) and goal tracking
- Reliable improvement/recovery metrics
- Use data to adapt dose/intensity and to step up/down



Evaluate the past and current treatments for Depression or GAD

Find out online how Depression or GAD was treated previously in the UK and summarise your findings in your own words.

- How was Depression or GAD described in the past?
- What are the main problems with the current ICD11 diagnosis and how do clinicians manage these?
- Be mindful to use only reliable and credible sources.

1. You could search for current reviews of GAD diagnosis and treatment.
2. Post your findings on the Week 4 Moodle forum.
3. Make sure you provide citations in your summary.
4. Read and respond to other's posts.

The focus of ICD11 diagnoses is:

- global applicability
- scientific validity
- clinical utility

In what ways is this focus helpful and unhelpful when helping people suffering from mental health problems such as Depression and GAD?



Improving access to NHS talking therapies?

Women consistently 66% of referrals (House of Commons Library (parliament.uk)).

What are the reasons? Prevalence? Cultural? Biological?

How could we help to improve access for men?



Addressing inequalities in access & outcomes

- Women ≈66% of TTAD referrals; men under-utilise services
- Deprivation/ethnicity linked to lower improvement/recovery in some areas
- Outreach strategies: workplace offers, flexible scheduling, community partners

Essential readings & sources



NICE NG222: Depression in adults (2022; reviewed 2024)



NICE NG116: PTSD (2018; reviewed 2025)



ICD-11 CDDR (2024): clinical descriptions



NHS England TTAD service standards & Annual Report 2023/24



CQC State of Care 2024/25



House of Commons Library: mental health policy/services (2024); TTAD statistics (2024)
