Behavioural and Cognitive Psychotherapy, 2018, 46, 761–767
First published online 13 June 2018 doi:10.1017/S1352465818000322

Preliminary Findings of a New Primary and Community Care Psychological Service in Northern Ireland: Low-Intensity Cognitive Behavioural Therapy for Common Mental Health Difficulties

Orla McDevitt-Petrovic, Karen Kirby*, Orla McBride, Mark Shevlin, Donal McAteer, Colin Gorman and Jamie Murphy

Ulster University

Background: The prevalence of mental health difficulties in Northern Ireland (NI) is significantly higher than in England. In recent years, there have been extensive consultations, and subsequent recommendations made in NI in an effort to address this. **Aims:** The current study aims to evaluate the effectiveness of an 'Improving Access to Psychological Therapies' (IAPT) stepped care service model using low-intensity cognitive behavioural therapy (LI-CBT) in primary and community care settings. **Method:** A pilot intervention trial design utilized two standardized outcome measures (PHQ-9 and GAD-7) before treatment (at baseline), during treatment (in every session) and at discharge (at final session). **Results:** Preliminary reliable change outcomes for the pilot cohorts showed a recovery rate of 47.9%, improvement rate of 76.7% and deterioration rate of 6%. **Conclusions:** These findings suggest that the IAPT service model is clinically effective in the NI population. Data collection for the larger study was completed in December 2017. Future analyses will include follow-up data collected at 4 months post-treatment, and will also aim to identify individual and service level factors that potentially impact treatment effectiveness.

Keywords: effectiveness, Improving Access to Psychological Therapies (IAPT), low intensity, psychological wellbeing practitioners, stepped care

Introduction

Improving Access to Psychological Therapies (IAPT) is a large-scale initiative first implemented in England in 2007, which aimed to improve access to evidenced-based psychological treatments for common mental health difficulties, primarily depression and anxiety (Gyani et al., 2013). The IAPT service model is informed by National Institute for Health and Care Excellence (NICE) guidelines, which recommend that mild to moderate depression and anxiety can be managed effectively using low-intensity interventions within primary care and community level settings (Department of Health, 2007).

* Correspondence to Karen Kirby, School of Psychology and Psychology Research Institute, Ulster University, Derry BT48 7JL. E-mail: k.kirby@ulster.ac.uk

© British Association for Behavioural and Cognitive Psychotherapies 2018

https://doi.org/10.1017/S1352465818000322 Published online by Cambridge University Press

Low-intensity interventions

'Low intensity' in this case refers to forms of CBT guided self-help that can be delivered in non-traditional formats (e.g. via telephone/online) and often require less practitioner support in terms of frequency and duration of sessions. The IAPT workforce delivering these interventions are referred to as psychological wellbeing practitioners (PWPs; Richards and Whyte, 2011). There is much evidence for the effectiveness of guided self-help which has a cognitive behavioural framework in the treatment of depression and anxiety. Please refer to the extended report online for a discussion of these reviews and meta-analyses (see Supplementary Material).

Effectiveness of the IAPT initiative

IAPT services are routinely evaluated using a session-by-session monitoring protocol, ensuring that each service user has a clinical end-point even where treatment is discontinued before expected. Evidence suggests that the IAPT model is clinically effective, and more specifically, that low-intensity interventions are an effective treatment for mild to moderate depression and anxiety. Gyani et al. (2013) examined year one data from 32 IAPT sites, representing approximately 19,000 clinical cases, and reported that 40% of individuals had reliably recovered and 64% had reliably improved by the end of treatment. In relation to low-intensity interventions specifically, Gyani et al. (2013), concluded that guided self-help was a significant predictor of reliable recovery where the diagnosis was depression, generalized anxiety or co-morbid depression and anxiety.

Moreover, the percentage of clients who were stepped up to a higher intensity service following guided self-help was 25.7%, compared with a figure of 54.5% for those who received pure self-help, which lends further support to the superior efficacy of guided self-help. These findings were in keeping with NICE recommendations whereby guided self-help but not exclusive self-help is advocated for mild/moderate depression.

Primary care level psychological therapies in Northern Ireland

Psychological therapy service provision in Northern Ireland (NI) has traditionally focused more on complex mental health difficulties. In 2013 the Northern Ireland Mental Health Services Threshold Criteria acknowledged that low-intensity therapists working at stepped care levels one and two, including those delivering low-intensity interventions, are crucial for the establishment of an effective stepped care approach to psychological therapy provision in the province (HSC, 2014); however local implementation of this has been inadequate (Betts and Thompson, 2017). Further details are provided within the extended report (see Supplementary Material).

Training of PWPs in Northern Ireland

In order to address this gap in service provision, a postgraduate programme has facilitated the training of PWPs (accredited by the British Psychological Society) since 2014. These trainees deliver low-intensity interventions within primary/community level services. Trainees attend university two days per week, and have one directed learning day on which a guided task is completed independently. Two days are spent seeing clients at placement sites after successful

https://doi.org/10.1017/S1352465818000322 Published online by Cambridge University Press

completion of assessment and intervention modules. Trainees attend individual clinical case management supervision on a weekly basis, and group clinical skills supervision sessions fortnightly as per IAPT accreditation requirements; all supervisors are either BPS or BABCP accredited practitioners and completed the IAPT PWP supervision training course (Richards and Whyte, 2011).

Aims and objectives

The current provision of psychological therapies at the primary/community care level in NI is in its early stages of development, with few empirical evaluations to date. The primary objective of this report is to present preliminary findings which evaluate change in clients' symptoms following treatment delivered by PWPs. Specifically, it was predicted that following a course of LI-CBT, there would be a reduction in PHQ-9 and GAD-7 scores indicative of reliable improvement and/or recovery, and that these would be similar to existing IAPT UK outcomes; thereby providing initial evidence that *this element* of the IAPT service model is effective in an NI context.

Methods

Design

This report presents the preliminary findings from a larger ongoing longitudinal study, using pre–post interventional trial methods, following clients (n = 199) from baseline (before therapy) through the course of low-intensity weekly treatment (1–11) sessions, and at discharge (final session). This preliminary evaluation is limited to examining changes in psychological wellbeing before and after therapy.

Measures

As per IAPT protocol, each client completed two routine outcome measures at *every session*, namely the Patient Health Questionnaire (PHQ-9; Kroenke and Spitzer, 2002) to measure depression, and the General Anxiety Disorder Questionnaire (GAD-7; Spitzer et al., 2006) to measure anxiety. A full overview of the measures is provided in the extended report.

Caseness and reliable change calculations

In keeping with IAPT recommendations (Gyani et al., 2013), the clinical outcomes reported here are related only to clients meeting 'caseness' criteria. This required at least two contacts with a PWP. A 'case' client must also have scored above clinical thresholds on at least one of the measures at assessment, indicated by 10 or above on the PHQ-9 and/or 8 or above on the GAD-7. A reduction or increase of six or more points on the PHQ-9 and a reduction or increase of four or more points on the GAD-7 have been determined as the thresholds for reliable change in depression and anxiety symptoms, respectively.

Clients are considered '*reliably improved*' if either measure score reliably decreased or the score for the other measure either remained the same or did not reliably deteriorate. Clients are considered '*reliably deteriorated*' if either measure score reliably increased, or the score

https://doi.org/10.1017/S1352465818000322 Published online by Cambridge University Press

for the other measure either also increased or did not reliably improve. A reliable recovery index was used in line with existing IAPT studies (Gyani et al., 2013). Clients are considered '*reliably recovered*' if they scored above the clinical threshold on at least one outcome measures at baseline, achieved overall reliable improvement, and scored below clinical thresholds on both measures at treatment completion. Further details are provided within the extended report.

Interventions

In keeping with the IAPT service model, PWPs ($n = 29$) supported clients by delivering a range of LI-CBT interventions, which included behavioural activation, cognitive restructuring, exposure therapy, problem solving, managing panic, sleep hygiene, and medication support. Further details are provided within the extended report.

Sample

Data were collected from 199 clients referred to a trainee PWP between January 2015 and June 2016. Referrals sources included GPs, Primary Care Team, Talking Therapies Hub, and self-referrals. The current study focuses on the clinical outcomes of the referrals who met 'caseness' criteria of which there were 104 (64%) females and 59 (36%) males. Ages ranged from 18 to 77, with a mean age of 39 years ($SD = 13.56$).

The duration of treatment ranged between two and 11 sessions, with a mean of 5.7 sessions. A total of 113 clients were discharged following successful treatment completion, and 50 were discharged before treatment completion due to either non-attendance or step up. Community settings within which a variety of wellbeing services are offered, facilitated treatment for 55% of case clients, 18% were treated in a GP practice, and 27% were treated at primary care psychological therapies service within a NI NHS Trust as per a stepped care framework. In relation to initial presentations, 25% of case clients demonstrated depressive symptoms, 14% presented with general anxiety and 47% with co-morbid depression and anxiety. The primary presentations of the remaining clients included specific phobia, panic disorder (with or without agoraphobia), health anxiety, and obsessive compulsive symptoms.

Results

In relation to depression, 59.5% of clients achieved reliable improvement and 3% showed reliable deterioration. In relation to anxiety, 70.6% of clients achieved reliable improvement and 5.5% showed reliable deterioration. Overall, 47.9% of clients who met caseness criteria demonstrated reliable recovery; 76.7% of these clients achieved reliable improvement, and 6.1% demonstrated reliable deterioration (see Table 1). There was no proportional difference observed in overall reliable recovery rates between clients treated in NI and those treated in England at the same time period [$\chi^2(1, n = 163) = 0.17, p > 0.5$]. However, the proportion of clients treated in NI who demonstrated overall reliable improvement was significantly higher when compared with rates in England [$\chi^2(1, n = 163) = 14.57, p < 0.001$].

https://doi.org/10.1017/S1352465818000322 Published online by Cambridge University Press

Table 1. Frequencies and percentages of reliable recovery, improvement and deterioration rates for all clients meeting caseness criteria ($n = 163$)

	Reliable improvement		Reliable deterioration		Overall reliable improvement	Overall reliable deterioration	Overall reliable recovery
	(PHQ-9)	(GAD-7)	(PHQ-9)	(GAD-7)			
Yes	97 (59.5%)	115 (70.6%)	5 (3.1%)	9 (5.5%)	125 (76.7%)	10 (6.1%)	78 (47.9%)
No	66 (40.5%)	48 (29.4%)	158 (96.9%)	154 (94.5%)	38 (23.3%)	153 (93.9%)	85 (52.1%)

At least two sessions attended and above clinical thresholds on one or both measures at baseline = caseness.

Discussion

Initial NI outcomes: clinical effectiveness

Findings from the current study are in keeping with outcomes from UK IAPT sites including the previously reported 2015/16 outcomes (HSC, 2016). More specifically, when NI reliable change rates are compared directly with these IAPT UK outcomes, recovery rates are 47.9 and 46.3%, respectively. Improvement rates are 76.7 and 62.2% for NI and England respectively, (HSC, 2016). These preliminary results provide initial evidence that low-intensity interventions are effective for mild to moderate level mental health difficulties in NI. The service evaluated in the current study is not an official IAPT service and trainee PWPs were not working under the usual high volume caseload, which may account partly for the higher improvement rates. Within IAPT UK, a client may have received both low- and high-intensity interventions. Given that *only low-intensity interventions were delivered and evaluated* in the current report, a higher proportion of suitable referrals within this sample may partly explain the higher improvement rates. Further discussion is included in the extended report.

Applying the evidence in Northern Ireland

Recent reports indicate that access to psychological services has been wholly inadequate in NI, and that significant funding is required to match provisions in England (Betts and Thompson, 2017). Currently, the mental health service framework in NI does not formally apply NICE evidence, as highlighted in the recent *Evaluation of the Bamford Action Plans* (Betts and Thompson, 2017). It is reasonable to assume that a PWP service in NI may reduce the prevalence of difficulties by improving access to psychological therapies at the primary care level, as the IAPT initiative has in England (Gyani et al., 2013).

Limitations

The absence of a control group is an acknowledged limitation of this pilot evaluation. The outcome data reported in the current study are limited, and future work will analyse a larger sample.

https://doi.org/10.1017/S1352465818000322 Published online by Cambridge University Press

Recommendations and plans for future low-intensity CBT research in NI

The collection of client data is ongoing, and reliable change will be examined based on this larger sample. Future research will also examine follow-up data and investigate predictors of treatment outcome, and changes in employment status and medication usage.

Conclusion

Our findings indicate that reliable recovery and improvement have been demonstrated for clients in NI with common mental health difficulties. This study provides evidence from NI that LI-CBT interventions (delivered by trainee PWPs) can be effective in the treatment of anxiety and depression at stepped care levels 1–3. Additionally, the Bamford evaluation highlighted a need to further promote psychological therapies, to improve access to services, and to improve involvement at the community and voluntary level (Betts and Thompson, 2017). Our initial findings indicate that PWPs could potentially address this need.

Acknowledgements

Ulster University would like to acknowledge the trainee PWPs and placement providers involved in delivering the intervention which has been evaluated.

Financial support: Orla McDevitt-Petrovic is funded by a studentship granted by the Department of Employment and Learning. The study was conceived and funded by Ulster University.

Ethics statement: Full ethical approval was obtained from ORECNI, with additional clinical governance obtained from three Trust sites in NI; IRAS ref. 181559; REC ref. 16/LO/0343. Data were fully anonymized prior to analysis by trainee psychological wellbeing practitioners.

Conflicts of interest: The authors report no conflicts of interest.

Supplementary material

To view supplementary material for this article, please visit https://doi.org/10.1017/S1352465818000322

References

Betts, J. and Thompson, J. (2017). Mental Health in Northern Ireland: Overview, Strategies, Policies, Care Pathways, CAMHS and Barriers to Accessing Services. Research and Information Service Research Paper. Northern Ireland Assembly. http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2016-2021/2017/health/0817.pdf

Department of Health (2007). IAPT outline service specification: Improving Access to Psychological Therapies (IAPT). https://www.uea.ac.uk/documents/246046/11991919/iapt-pathfinder-outline-service-specification.pdf/9fc11891-ecc5-48e4-a974-9bbc8ab0c690

https://doi.org/10.1017/S1352465818000322 Published online by Cambridge University Press

Gyani, A., Shafran, R., Layard, R. and Clark, D. M (2013). Enhancing recovery rates: lessons from year one of IAPT. *Behaviour Research and Therapy*, *51*, 597–606.

Health and Social Care Board (HSC) (2014) You In Mind. Mental Healthcare Pathway. http://www.northerntrust.hscni.net/pdf/Care_pathway_for_people_who_require_mental_health_care_and_support.pdf

Health and Social Care Information Centre (HSC) (2016). Psychological Therapies, Annual Report on the use of IAPT services.

Kroenke, K. and Spitzer, R. L. (2002). The PHQ-9: a new depression diagnostic and severity measure. *Psychiatric Annals*, *32*, 509–515.

Richards, D. A. and Whyte, M. (2011). Reach Out: National programme student materials to support the training and for Psychological Wellbeing Practitioners delivering low intensity interventions. UK: Rethink Mental Illness, 2011. https://cedar.exeter.ac.uk/media/universityofexeter/schoolofpsychology/cedar/documents/Reach_Out_3rd_edition.pdf

Spitzer, R. L., Kroenke, K., Williams, J. B. and Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine*, *166*, 1092–1097.

https://doi.org/10.1017/S1352465818000322 Published online by Cambridge University Press