

# Low intensity Psychological interventions in Aotearoa: What can we learn from IAPT?

Beverly Haarhoff and Mei Wah Williams  
*Massey University, Auckland*

Low Intensity psychological interventions are designed to provide cost effective, brief evidence-based psychological interventions to a growing population of individuals who suffer from mild to moderate mental health problems. Low Intensity Cognitive Behavioural Therapy (LICBT) has been proposed as a paradigm shift in the delivery of mental health services aimed at increasing service access and reducing expensive specialist time. In New Zealand primary, secondary, and tertiary mental health services are clearly differentiated and psychological interventions (brief or longer term) are generally delivered by specialist practitioners at each level of service. The paper describes LICBT, developed and delivered in England as part of the National Health Service's integrated, five-tier, stepped care mental health service. This stepped care model will serve to illustrate the paradigm shift in the delivery of mental health services. The successes and challenges of such an initiative are considered.

**Keywords:** low intensity psychological interventions, stepped care, psychological wellbeing practitioner, self-help

Increasingly, common mental health disorders such as depression and anxiety are recognised as leading causes of disability throughout the world (World Health Organisation, 2016). Poor mental health impacts on an individual's physical health, family life, and workplace functioning. For example, in the UK depression is considered 50% more disabling than angina, asthma, diabetes or arthritis, and accounts for 40% of government benefits paid and 40% of work absenteeism (Clark, 2016). Effective treatments are available but relatively few receive these. It is estimated that less than 10% of the world population are appropriately diagnosed and treated. The reasons for the scarcity of effective treatment are identified as a lack of resources and trained mental health providers, the social stigma attached to mental health problems, inaccurate assessment, and the fact that these conditions appear to be on the rise globally (World Health Organisation, 2016). Mental health services, particularly in the developed world, including New Zealand, are under increasing pressure to substantially improve, or at least manage this situation more effectively. The National Health services in England

have, over the past decade, risen to the challenge by initiating the Improving Access to Psychological Therapies programme (IAPT, 2008).

Low intensity psychological interventions are a key element of this ambitious and wide ranging initiative (Clark, 2011). Two important factors stimulated the growth of low intensity options for mental health problems. These were, the development of the National Institute for Clinical Excellence (NICE) guidelines for the treatment of depression (NICE, 2004a) and the anxiety disorders (NICE, 2004b), and Layard et al.'s (2006) report on the huge economic cost and social burden of the global increase in anxiety and depression. Layard et al.'s (2007) subsequent economic analysis and intensive lobbying regarding the cost benefits of improving access to evidence based psychological interventions resulted in the Improving Access to Psychological Therapies (IAPT) initiative in England. On the basis of the "spend to save" rationale, an investment of 175 million pounds per annum was allocated to the National Health mental health service between 2008 and 2011 to train cognitive behavioural therapists, (identified as a scarce resource), and to

implement a stepped care mental health services model (Clark, 2011). It was posited that the cost of implementing these initiatives would be recovered through a reduction in medical costs and welfare payments, and through increases in revenue gathered from return to employment and improved productivity (Layard et al., 2007).

This paper aims to introduce some of the ideas behind the development of this relatively new therapeutic paradigm to Aotearoa New Zealand mental health community. Low Intensity CBT (LICBT), as practised in England, is defined and described in terms of its mode of delivery, type of intervention, and the primary reliance on CBT as the guiding model for practice. One of the central pillars of LICBT is the introduction of "low intensity" mental health practitioners called "Psychological Wellbeing Practitioners" (PWPs). The PWP role is discussed and contrasted with that of the High Intensity Practitioner (specialist mental health practitioners, such as clinical psychologist or mental health nurse). In addition, a brief overview of the research supporting the introduction of LICBT is provided. The paper concludes by highlighting some of the challenges in delivering LICBT in England.

## *What is Low Intensity therapy?*

The significant gap between the demand for mental health services and the availability of specialist providers to service this need has prompted the search for alternative approaches in the delivery of psychological interventions (Haaga, 2000; Lovell & Richards, 2000). Low intensity (LI) psychological interventions have been developed to bridge this gap and are associated with "low usage of specialist therapist time" (Bennett-Levy, Richards, & Farrand, 2010, p. 4). As such, the main purpose of LI interventions is

to increase access to evidence based psychological interventions for the growing population of individuals suffering from mild to moderate mental health problems, such as depression and the anxiety disorders. This requires a new way of thinking about the delivery of intervention programmes or a “new paradigm” (Bennett-Levy et al., 2010, p.12) that does not increase the burden of funding on taxpayers. Traditional psychological interventions are typically delivered by specialist professional mental health practitioners, referred to as High Intensity (HI) practitioners under IAPT. These practitioners graduate after lengthy years of training and are considered an expensive and scarce resource. They generally see only a limited number of clients presenting with serious or chronic problems. Hence, a cornerstone in the delivery of LI psychological interventions has been the introduction of Psychological Wellbeing Practitioners (PWP) as a new type of practitioner. These practitioners are trained in new modes of service delivery (e.g. through the Internet, SMS, and telephone), and focus on briefer evidence-based psychological interventions. The interventions, often in the form of a manualised treatment protocols, are delivered and supported by PWPs and in some instances, used by the client independently as “self-help” programmes. In England the LI model is situated within a stepped care IAPT service where clients can either be “stepped up” and receive more specialised interventions if they become unwell, or be “stepped down” to primary or community care as they improve. In summary therefore, LICBT, as part of stepped care, consists of a limited number of evidence-based brief psychological interventions, delivered by PWPs using a variety of modes of delivery, such as the internet or self-help workbooks. It is important to highlight that the aim of LI options, within a stepped-care system, is to complement the existing HI approaches and that LI interventions are not designed to replace or prevent access to the specialised skills of highly trained practitioners.

### ***Why Low Intensity Cognitive Behavioural Therapy?***

Why has Cognitive Behavioural Therapy (CBT) been selected as the core therapeutic model underpinning LI interventions? CBT has a solid reputation as an evidence-based talking therapy (Westbrook, Kennerley, & Kirk, 2011) and has been shown to be effective across the spectrum of mental health problems from mild to severe. It has been defined as a problem focused, short-term therapy (Beck, 1995), especially when contrasted to psychodynamic models of therapy. CBT interventions are clearly specified and designed to target common difficulties such as negative thinking, low mood, poor motivation, problem solving difficulties, lethargy, and fears and phobias of various kinds. Furthermore, the interventions translate to tangible worksheets, such as activity schedules to enhance behavioural activation, thought diaries to assist with unhelpful thinking, decision making and problem solving tools, and a variety of strategies to encourage monitoring and tracking unhelpful behaviours, thoughts, emotions, and triggers. In addition, over the past three decades disorder specific protocols targeting diagnoses, such as panic and social anxiety, have been developed (Wells, 1997). These protocols are manualised with interventions clearly described. There are also a number of well supported transdiagnostic interventions (Farchione, Fairhome, Ellard, Boisseau, Thompson-Hollands, Carl, Gallagher, & Barlow, 2012) which can be used to target several different diagnostic presentations (McHugh & Barlow, 2012).

The elements of CBT are easily dismantled into simplified components. For example, behavioural activation, identifying thinking errors, and problem solving are used in the treatment of major depression. These multi-components can be disassembled and used separately for the treatment of mild to moderate depression, for example behavioural activation as a complete intervention (e.g. Jacobson et al., 1996). It is this clarity and simplicity that have made CBT compatible with the goals of LI interventions.

It should be noted that CBT was originally developed as an alternative to

the established influential psychoanalytic model. Psychodynamic therapy was often conducted over several years, with clients frequently attending daily hourly sessions with a psychoanalyst. In contrast, CBT was delivered over 12-20 hourly sessions by a specialist clinical psychologist or psychiatrist, and was considered, due to its brevity, to be somewhat superficial according to psychoanalytic standards. In the 21st century however, it is now the original CBT protocol developed by Aaron Beck (1976) and elaborated by Judith Beck (1995; 2011a), that is considered to be time consuming, expensive and, within managed care, more useful for those with severe and/or chronic psychological difficulties.

### ***A new kind of practitioner: Enter the Psychological Wellbeing Practitioner***

The IAPT initiative has distinguished what have come to be known as High and Low intensity practitioners. HI practitioners are typically those who are graduates of professional training programmes; most often clinical psychologists, specialist nurse practitioners, psychotherapists, and psychiatrists. These practitioners deliver therapy in what has come to be accepted as “the way therapy is done”; for example, individual, weekly sessions, scheduled for one hour with a specialist. Therapy is assumed to be evidence-based, guided by the theoretical orientation of the practitioner, based on an individualised case formulation approach, and tailored to the client’s specific needs. The therapeutic relationship is considered an important, if not key, element and is often employed as an intervention to facilitate interpersonal insight and understanding (Persons, 1989; Safran & Segal, 1990).

The rationale behind the introduction of the PWP role was first, to limit HI intervention to more serious and complex presentations thus decreasing expensive and scarce specialists’ time and, secondly, to see a larger number of clients than would habitually be treated by the HI practitioner. PWPs are not recruited from graduates of traditional mental health professional training programmes, such as psychologists and

psychotherapists and can come from many walks of life. The preferred PWP workers are individuals who come from diverse groups that reflect the specific socio-cultural mores of the communities they serve. In reality, however, many PWPs do have a background in mental health training and may view the PWP training as a career pathway to becoming a HI practitioner.

PWPs are pivotal to the delivery of LICBT in the IAPT stepped care model, as shown in Table 1. In the five-step care system, the PWP workforce works at Step 2 to support LICBT initiatives for high prevalence mild to moderate mental health problems (Bennett-Levy et al, 2010). At each step, an increasing level

of therapeutic intervention and specialist services are offered. Disorders such as severe depression, anxiety disorders such as PTSD, and other chronic problems such as eating disorders, are earmarked as needing HI interventions and are therefore seen at Step 3 and above.

Typically, PWPs provide clients with 30-40 minute assessment (Farrand & Williams, 2010), followed by some form of intervention and/or support sessions lasting up to 30 minutes (British Psychological Society, 2012). The average number of support sessions is around five sessions. This quicker turn around means PWPs have large caseloads of between 60-100 clients. Clients are regularly reviewed (at least

every 4 weeks) within case management supervision (which will be elaborated on later) and they can be stepped up to receive HI treatment or to secondary care if necessary (NICE, 2011). It should be emphasised that the availability of “higher steps” offering HI interventions are considered vital to the delivery of LICBT, if it is to be successfully embedded in a mental health service (Farrand, personal communication 25 February, 2016).

**Psychological Wellbeing Practitioner Training**

In England, trainee PWPs attend 25 days of university teaching and 20 days of university-directed study at their workplace where they are expected to take responsibility for their own learning (this is obviously far less than what would be expected for HI practitioners).

The training consists of four modules listed below:

1. Engagement and Assessment of Patients with Common Mental Health Problems
2. Evidence Based Low Intensity Treatment for Common Mental Health Disorders
3. Values, Policy, Culture, and Diversity
4. Working within an Employment, Social, and Healthcare Context.

(Richards and Whyte, 2009, p.8)

Assessment on each of the modules consists of competency-based role-plays, requiring reflective commentary. PWPs also pass a final written examination. PWP training can be difficult for those who have never engaged in formal tertiary education, especially as the training relies heavily on personal responsibility and independent learning in the workplace. The training is often perceived as challenging by PWPs as they are expected to co-ordinate learning experiences alongside facilitating learning opportunities within the clinical setting in which they are employed (Farrand, Rayson, & Lovis, 2016).

**Psychological Wellbeing Practitioner Supervision**

As with training, clinical supervision has been modified to fit the new PWP role. Labelled clinical case management

Table 1.

*The recommended stepped care system for the treatment of depression\**

| Step     | Location   | Service                                 | Intervention                                       | Responsive conditions  | Possible outcomes                |
|----------|--|---|--|--|----------------------------------|
| Step 1   | Primary care: Physician’s clinic                                 | Primary care: Physician or Nurse        | Assessment, CBT based psycho-education, monitoring | Mild, self-limiting  | Client recovers or is stepped up |
| Step 2** | Primary Mental Health Team                                       | LICBT practitioner                      | LICBT  | Mild to moderate high prevalence psychological problems                            | Client responds or is stepped up |
| Step 3   | Primary Mental Health Team                                       | High Intensity CBT (HICBT) practitioner | HICBT  | Moderate to severe   | Client responds or is stepped up |
| Step 4   | Mental health specialists including Crisis Assessment Team (CAT) | Multi-disciplinary                      | Usually incorporates CBT                           | Treatment resistant, recurrent, atypical or psychotic depression, significant risk | Client responds or is stepped up |
| Step 5   | Inpatient care or CAT  |   |  | Risk to life, self-neglect   |                                  |

\*(Papworth, 2013, p. 12)

supervision (CMS), this new form of supervision is defined as:

*.... regular review of the caseloads of practitioners providing low intensity interventions within IAPT stepped care services. It is undertaken at regular (usually weekly), timetabled intervals and is informed by automated IT-based case management systems. A large number of cases will usually be discussed in any one supervision session. Discussions in case management supervision always include supervisee presentations of patients at pre-determined stages in their care pathway and/or who have particular clinical characteristics.*

(Turpin & Wheeler, 2011, p.6)

CMS is designed to support the PWP by ensuring all clients are discussed, maintain fidelity to evidence-based practice, ensure safe practice, and decide whether the client needs to be “stepped up or down”. CMS can be challenging due to the volume of clients that are required to be discussed within a relatively short space of time. Ideally CMS is complemented with more traditional skills-based supervision that concentrates on the “development and maintenance of competence” (Turpin & Wheeler, 2011, p.6).

### ***The Therapeutic Relationship and the Psychological Wellbeing Practitioner***

Numerous research studies across diverse models of psychotherapy confirm the therapeutic relationship as a key common factor influencing therapeutic outcome (Wampold, 2001), and the way in which the therapeutic relationship is conceptualised is important in distinguishing high and low intensity therapies (Farrand et al, 2016). The relative importance of the therapeutic relationship in LICBT remains a subject of debate. In early cognitive behavioural therapies, the adherence to manualised treatment protocols was prioritised over the therapeutic relationship. However, in recent decades, as CBT has expanded to address increasingly complex client presentations, the importance of the interpersonal process between therapist and client is widely recognised as an important element in the overall formulation of the client’s presenting issues in HI CBT (Davidson, 2008;

Safran & Segal, 1990; Young et al., 2003). In contrast, because PWPs deliver short-term psychological interventions to clients who present with mild to moderate mental health problems, manual adherence is emphasised and the therapeutic relationship perceived as “background” rather than an intervention in itself. This means focusing on factors necessary to facilitating productive working relationship (e.g. positive regard, respect, empathy, collaborative stance) (Persons, 1989). In this model the therapist is characterised as an encouraging, facilitative coach.

From a different perspective, Chaddock (2013) argues that because PWPs have a high and heterogeneous client case load, the vehicle of the therapeutic relationship may actually be even more important than in “traditional” CBT. This is due to the fact that PWPs see clients for a relatively short period of time, making the ability to engage the client of considerable importance. However the argument that interpersonal process may be less important in the treatment of mild to moderate mental health problems has been supported by a recent meta-analysis of CBT self-help interventions, which found that there was no statistically significant difference in overall mean effect size whether guided, supported, partially supported, or self-administered intervention was used (Farrand & Woodford, 2013). This tension regarding the relative importance of the PWPs interpersonal skill has implications for those involved in PWP training curriculum development and remains an issue often highlighted by those critical of LI psychological interventions. One of the papers included in this special edition, authored by Thwaites and colleagues, discusses this issue in greater detail.

To conclude, it may be that instead of referencing the “therapeutic relationship”, which has connotations conjuring constructs such as transference and counter-transference, “therapeutic engagement” might better describe what an effective PWP is able to achieve.

### ***Self-practice/self-reflection***

While therapeutic interpersonal process may have less prominence within a LICBT approach, understanding the process of change and the underlying

principles of the CBT model is an important consideration. Self-practice/self-reflection (SP/SR) is an experiential training initiative which requires practitioners to apply CBT interventions to themselves (SP) and reflect on the process in a structured way (SR). Over the past 15 years, qualitative evidence has accumulated from several countries and across a number of different practitioner populations, including trainees and experienced PWPs (Farrand, Perry & Linsley, 2010; Thwaites et al., 2015), showing SP/SR to be helpful in a number of key areas of therapist professional and personal development. This includes enhanced application and understanding the CBT model and the process of change, most particularly in the interpersonal domain (Bennett-Levy et al., 2015, Gale & Schroder, 2014). There are currently initiatives afoot in England to introduce SP/SR into both the training and support of PWPs (Farrand et al., 2010; Thwaites et al., 2015). SP/SR, delivered in workbook format, in many ways mirrors the manualised treatment protocols used in LICBT, and it could be speculated that it might have an important role to play in the training of these practitioners.

### ***Low Intensity CBT in Action***

#### ***The initial contact***

Typically, a client’s presenting problem will be operationalised using a situational formulation model such as the five-area assessment (Dummett & Williams, 2008). The client is encouraged to reflect on the way in which the five areas, namely people and events (triggers), altered thinking, feeling or emotions, physiological sensations, and behaviour interact to maintain and worsen the problem. Once identified and collaboratively understood, the problem is targeted with a specific intervention(s) presented in a manualised format. For example, if poor sleep is identified as a problem a workbook or internet programme is introduced to help the client learn about sleep and sleeplessness through psycho-education, identifying common causes of sleep problems, and using a sleep diary to monitor sleep patterns and recognise what makes things better or worse. Using this knowledge, the client can institute changes in a structured supported way with a PWP

(Dummett & Williams, 2008 p. 249-264).

Additionally, IAPT (2008) places a strong emphasis on measuring treatment outcomes and a number of simple core outcome measures, such as the Patient Health Questionnaire-9 (PHQ-9: Kroenke, Spitzer, & Williams, 2001) and Generalised Anxiety Disorder-7 (GAD-7: Spitzer, Kroenke, Williams, & Lowe, 2006) are routinely used to track progress. The management of risk is also an important consideration in the initial assessment and formulation.

### Self-help materials

A cornerstone of LICBT is the use of self-help materials in a variety of formats. Self-help books have a long history and in more traditional high intensity therapy they are generally seen as something to be used *alongside* high intensity therapy. In LICBT the self-help materials take centre stage as it is within the materials that the curative elements are assumed to reside. In this model the PWP takes a secondary role as facilitator or coach who supports, encourages, and helps the client to get the most out of the self-help tools (Williams, Farrand & Bennett-Levy, 2010) and in some instances self-help materials may be utilised in an unsupported or self-administered context.

### What is the evidence for LICBT?

The IAPT service has a strong commitment to regular evaluation, and shortly after the UK Government launched the IAPT initiative two demonstration sites, Doncaster and Newham, were selected in 2006 as the pilot and evaluation of the stepped care approach (Clark, 2011).

Significant funding was given towards the training of a new workforce to implement the LI and stepped care model. One year into the trial, over 3500 people were seen across the two sites, with 90% of the referrals coming from general practitioners. Most people seen were of employable age, as return to work was an important aspect of the treatment outcome. The initial evaluations confirmed the successful outcome of LI initiatives. Over 50% of people who completed treatment were reported as fully recovered from depression and anxiety disorders on the outcome measures; a recovery rate comparable to randomised control trial

studies. Furthermore, approximately 5% were back into employment; a number predicted in Layard et al. (2007) report. However, compliance with the NICE guidelines to use a stepped care model was modest, and there was limited follow-up to assess the maintenance of gains after treatment.

After the success of the two demonstration sites, the IAPT model was expanded to 11 primary care trusts (PCT) throughout England; named Pathfinder pilot sites (IAPT, 2008). The LI interventions were offered to a wider and more diverse population, such as older adults, children and adolescence, offender, ethnic minority groups, young mothers, and people with long standing health problems. Self-referrals were accepted as a referral source in order to increase equity of access to the services, as well as it was found that fewer sessions were required for this group to achieve recovery (Clark, 2016). The findings mirror that of the demonstration sites in that nearly 50% people reached subclinical thresholds after treatment. The study also emphasised the importance of following the NICE guidelines, as outcomes were poorer when treatment for specific disorders deviated from the recommended treatment (Clark, 2011). One of the main conclusions from the study was that access to the full range of high and low intensity interventions was critical to improvement in recovery rates in treatment.

### Challenges and Future Directions

Evaluation of IAPT is, of course, ongoing and as discussed below there has been some critical debate regarding the research questions asked, implementation of the IAPT project and the parameters of success chosen (Cooper, 2012). This paper has presented what could be perceived as a somewhat idealised account of the introduction of LICBT as part of the IAPT stepped care service. There have been significant challenges facing the transformation of mental health services, along with a number of criticisms and concerns levelled at the IAPT initiative as a whole and LICBT in particular. It is beyond the scope of this paper to unpack and respond to the critical discourse in detail and the reader is encouraged to critically consider the main themes summarised below.

Critics have characterised the IAPT

initiative as “industrialised talking therapy” which objectifies both client and process of therapy by promoting routinized, manualised, one size fits all therapy (Chapman, 2012, p. 34). The emphasis on RCTs as the gold standard underpinning evidence-based therapy is critiqued as promoting Positivist or Post-Positivist ideology at the expense of other theories of knowledge, particularly those which eschew quantifiable data (e.g. symptoms and behaviours). There is a view that what is characterised as an “audit culture” stifles the subjective creativity of the clinician, so that the “art” of psychotherapy is entirely lost to the science! There are further concerns regarding CBT. Some believe that the CBT model is privileged as the dominant therapy as it fits the empiricist mode by targeting measurable symptoms, behaviours and outcomes. It is suggested that little is known about the long term benefits of other therapies and that social risk factors such as poverty, poor relationships, and lack of housing are not addressed by psychological therapies (Cooper, 2012). There are also concerns that the increased use of the internet and computerised therapy programmes conjure a “nightmare of a truly digitised therapy” (Chapman, 2012, 42). Therapists from other modalities, particularly counsellors and psychotherapists have reported feeling excluded (Lewis, 2012; Risq, 2012) and there is discomfit with the competency frameworks which, once more, are perceived as straightjacketing clinical practice. Finally, there are those who take a broader socio-political stance arguing the emphasis on making the individual responsible for taking steps to ameliorate mental health difficulties obscures contextual problems such as poverty, cultural alienation, etc. (Cooper, 2012).

All of these criticisms, although seeming to represent only a relatively small sector of practitioners (Chapman, 2012), deserve attention, particularly those which concern the wider socio-political context.

Turning more specifically to LICBT, Telford and Wilson (2010), both of whom are PWPs, identify challenges from what they described as the “shop floor” of LICBT delivery. These challenges are:

- Negative reactions from other mental health professionals to the idea

of LI interventions

- Concerns expressed by HI practitioners regarding PWP's assessment capability
- Case management as a supervision model
- What has been termed "therapeutic drift"

These challenges are discussed below.

Negative reactions from other mental health professionals are listed above. Practitioners adherent to psychodynamic and humanist existential psychotherapies have reported perceived marginalisation whereby CBT practitioners are seen as "privileged" as described the following quote: "The CBT minority was seemingly overnight upgraded from bedsit to mansion" (Lewis, 2012, p25). Other concerns centre on the following beliefs: the CBT model is being oversimplified and dumbed down, comprehensive assessment and individualised formulation are being sacrificed to rote-like cookbook delivery of treatment protocols, and the perception that PWPs have not "served their time" in undergoing an extensive academic and professional education. It is suggested that some of these criticisms may arise due to fears that the PWP's role will replace that of HI practitioners and that PWPs will increasingly get to work with severe and chronic mental health conditions, thus squeezing specialist practitioners out of the workforce. Telford and Wilson (2010) suggest that many of the concerns result from poor communication and education regarding the LI paradigm and principles, and recommend that practitioners wedded to more traditional approaches need to be proactively engaged in ongoing dialogue and education. For example, the training of PWPs emphasises the importance of assessment and that the high volume of clients seen by PWPs means that as a group they have accumulated considerable experience in this area. Under the CMS model all the clinical work done by PWPs is closely scrutinised. Concerns regarding assessment could be allayed by services working collaboratively to develop standardised assessment protocols. Critics should be reminded also that LI interventions target the population experiencing mild to moderate levels of

mental illness, which are currently not seen by HI practitioners. This group of clients would fail to receive any effective treatment at all if they were not being seen by PWPs. This client population may benefit from LI type interventions, such as guided self-help, that emphasises a move away from the expertise of the practitioner to that contained within the contents of the material, and which the PWPs are trained to deliver.

The challenge in instituting CMS has also been identified as a problem, with supervisors concerned that the volume of clients to be reviewed is unrealistic. Telford and Wilson (2010) recommend that more targeted training to support supervisors' transition to this new role is necessary.

Another more serious challenge identified has been named "therapeutic drift", which is the tendency for PWPs to migrate towards less evidence-based interventions and/or to treating problems using HI interventions for which they have not been trained. For example, eliciting and working on entrenched schema and core beliefs. This problem is not limited to IAPT services. The dissemination and implementation of evidence-based psychological interventions in clinical services in other health services in developed countries is reported to be uneven at best (McHugh & Barlow, 2012). A variety of reasons for the "research-practice gap" are suggested. This a complex field and three broad areas of challenge are identified namely: the motivation of providers, training barriers and organisational systems barriers (see McHugh & Barlow, 2012 for more detailed analysis).

In a seminal paper, Shafran and colleagues (2009) highlight the gap between the optimal delivery of empirically supported treatments, such as CBT, and the competency and adherence to evidence-based treatment by therapists. They identify three common "therapist beliefs" that have contributed to therapist drift. These are:

1. Research trials have limited relevance to clinical experience: "Research trials recruit clients with straight forward diagnosis that do not mirror the complexity of real life clinical practice".
2. Clinical outcome depends solely on therapist factors: "It doesn't

matter what you do as long as you have a "good relationship with the client".

3. Diagnosis and protocol adherence oversimplify the problem and ignore idiosyncratic presentations: "Protocols are just cookbooks".

Each of these beliefs can be challenged by attending to the research, which in a nutshell states that firstly, clinical trials actually recruit participants from the more severe end of the diagnostic continuum and are more attentive to the participants showing a greater severity of symptoms presented. Participants with milder or fewer symptoms are likely to be excluded from RCTs. Secondly, the more closely evidence-based protocols are adhered to, the more likely it is that the outcome will be favourable (Whittington & Grey, 2014). CBT protocols are designed to be used with an individualised formulation (Beck, 2011b). Therapist factors are important but more often it is those therapists who practise in an adherent and theoretically consistent manner that achieve a solid therapeutic alliance and more consistently positive outcomes. Whittington and Grey (2014) report that unfortunately even those who deliver training programmes in CBT may ignore this research and be guided by similar unsupported beliefs, leading to "therapeutic drift" from the top down.

There are also challenges involved in training the new workforce. As previously mentioned this involves the PWP managing university and workplace commitments simultaneously. A high level of responsibility for self-directed learning is required and the expectation in some overstretched services often can be that the PWP takes on a full case load from the outset (Farrand et al., 2016). In a recent study exploring the uptake of an experiential professional development opportunity (SP/SR), a lack of time was identified as a major obstacle to participation with 62% of those canvassed identifying this as an obstacle to training. This is illustrated in a participant's comment:

*"I thought my workload was already too high and having to find time outside of work when I was already at maximum mental capacity after getting home from work most days"*

(Haarhoff, Thwaites, & Bennett-Levy, 2015).

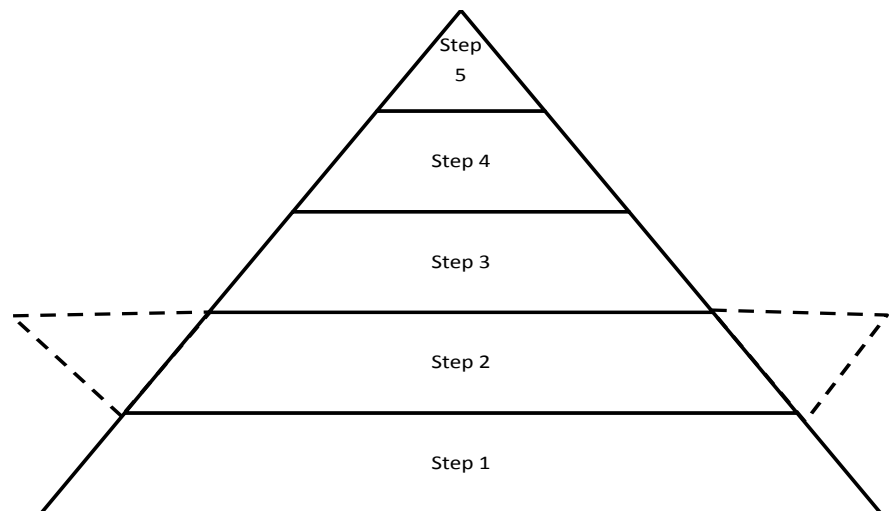
Many of these challenges can be addressed by proactively educating the mental health providers. However, some aspects such as therapist adherence and competency are more complex. Shafran and colleagues (2009) provide eight recommendations regarding the improved utilisation of empirically based treatments. The two most relevant for LICBT seem to be firstly, clinicians should have easy access to training in diagnostic and routine outcome measures which they should be encouraged to use regularly (*and react to*) and, secondly, that methods to accurately distinguish which clients will benefit from LI or HI interventions need to be developed.

In spite of these challenges, the IAPT stepped care initiative in England, within which LI psychological interventions are a key component, has transformed the treatment of anxiety and depression in England, and is generally considered a “resounding” success (Clark, 2016, Freeston, 2016). For example, stepped care psychological intervention services are established in every area of England, and there is a marked increase in self-referrals (Clark, 2016). Other markers of success include improved throughputs, shorter wait times, more targeted services, increased training opportunities, and development of the workforce, including training in supervision. In addition, outcome data is obtained in 97% of cases, and most importantly, the public profile of psychological interventions has been raised in a positive way. Finally, there has been an increase in the number of trained CBT therapists and in the delivery of evidence-based psychotherapies (Freeston, 2016). Freeston concludes that the “landscape has fundamentally changed” in the UK, to the extent that other countries, for example Australia, are closely watching and adapting services to mirror changes in England.

#### What is the future for IAPT?

Two keynote addresses at the 8th World Congress of Cognitive Behavioural Therapies in Melbourne considered this question seriously (Clark, 2016; Freeston, 2016).

Both recognised the “burden” of success. Far more people are seeking and accessing treatment for mental health issues. Freeston noted that the oft depicted stepped care pyramid, has not only increased in size but also changed



Step1: Recognition, watchful waiting; Step 2: Low Intensity interventions, mild to moderate depression and anxiety & (*something more*); Step 3: High Intensity interventions, moderate to severe; Step 4: Specialist services, severe, treatment resistant, complex, atypical, risk; Step 5: Inpatient, crisis, risk to life.

Figure 1. The changing shape of IAPT stepped care service (Adapted from Freeston, 2016)

its shape (see Figure 1).

There are now more people in the system with presenting issues which appear to have grown in complexity. There are new combinations of symptoms and diagnoses, for example, medically unexplained symptoms, intellectual and learning disability, autism spectrum disorders, and personality disorders. No longer simply, “anxiety and depression” but, “anxiety and depression”, and “something more”. This has meant that increasing demands are predicted to occur at step two; the LI step. Step two is the first entry after step one, “watchful waiting”. This will have implications for PWPs who currently deliver psychological interventions at this step. Freeston asks, “Will this group need more or different supervision and additional competences to cope with increasing complexity?”. “Who will provide training and supervision in an already stretched pool of expertise?” Freeston is interested in the potential of targeting core transdiagnostic factors such as low tolerance of uncertainty and avoidance, and developing protocols to target these, thus simplifying delivery (targeting more symptoms with less interventions see Barlow, Allen & Choate, 2004).

Clark (2016), the English National

Clinical Advisor to IAPT, is enthusiastic about the power of internet delivery of psychological protocols and interventions and sees the internet use as a mechanism to future proof current services. He proposes several advantages in increasing the use of digital platforms namely:

- More consistent delivery of evidence-based protocols (this also offers an opportunity to use highly skilled specialists in the treatment delivery process)
- Equal access to highly skilled delivery of protocols
- The ability to treat everyone at the same cost as only treating 15%-20% (the status quo)
- An 80% reduction in therapist time
- A reduction in stigma (individuals can access therapy when and where they choose)
- Enhanced outcome evaluation as there will be more consistent delivery of treatment, large samples will be readily available, and new interventions can be rapidly evaluated.

### Implications for Aotearoa New Zealand

The situation in New Zealand mirrors the global experience and escalating levels of depression and anxiety disorders, chronic shortages of skilled professionals, particularly GPs and perceived funding shortfalls are consistently reported in the media. An aspirational goal for local policy makers is to manage this situation in a way that acknowledges the international consensus for equity of access to psychological services, and endorses the goal to provide psychological support to all that need it.

The current paper is not aimed at proposing an alternative mental health direction in New Zealand. We do however feel that there are lessons to be learned from the successes of IAPT. David Clark (2016) concluded his seminal keynote address with advice for the international audience interested in developing stepped care models along the lines of IAPT. He emphasised the following as key elements:

- The development of evidence-based clinical guidelines such as those delivered by NICE
- The importance of consistent collection of outcome data, to support and build the case for increased funding
  - Recruiting support from patients and clinicians
  - Delivering on time for the politicians
  - The creation of what he called, “an innovation environment” within which recovery- focused clinicians would deliver effective evidence-based psychological interventions.

All of these points seem worthy of consideration if New Zealand is going to move forward with a more inclusive, effective and sustainable mental health service. We would add that training low intensity practitioners in the delivery of evidence-based psychological interventions could be a significant innovation in developing a new arm of the established mental health services. In the next paper we describe the current mental health service in New Zealand, the changes that have been occurring with primary mental health service delivery, and consider additional pathways towards a mental health service delivery that can respond to the

burgeoning demand for these services.

### References

Beck, A., Rush, J., Shaw, B., & Emery, G. (1976). *Cognitive Therapy of Depression*. New York: Guilford Press.

Beck, J. (1995). *Cognitive Therapy: Basics and beyond*. New York: Guilford Press.

Beck, J. (2011a). *Cognitive Therapy Basics and beyond*. (2nd edition). New York: Guilford Press.

Beck, J. (2011b). *Cognitive Therapy for Challenging Problems* (2nd edition). New York: Guilford Press.

Bennett-Levy, J., Richards, D., & Farrand, P. (2010). Low intensity CBT interventions: A revolution in mental health care. In J. Bennett-Levy, D.A. Richards, P. Farrand, H. Christensen, K. M. Griffiths, D. J. Kavanagh, B., .... C. Williams (Eds.). *Oxford guide to low intensity interventions*. (pp. 13-18). Oxford: Oxford University Press.

Bennett-Levy J., Thwaites R., Haarhoff, B., & Perry, H. (2015). *Experiencing CBT from the Inside Out: A Self-practice/Self-reflection CBT workbook for therapists*. New York: Guilford Press.

British Psychological Society (2012). *Psychological wellbeing practitioner training: accreditation handbook* (3rd edition.). Leicester: British Psychological Society.

Chaddock, A. (2013). The therapeutic relationship: Big deal or no deal? In M. Papworth, T. Marrinan & B. Martin. *Low Intensity Cognitive Behaviour Therapy: A Practitioner's Guide*. (pp. 69-84). London: Sage.

Chapman, L. (2012). Evidence-based practice, talking therapies and the New Taylorism. *Psychotherapy and Politics International*, 10 (1) 33-44.

Clark, D. M. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: The IAPT experience. *International Review of Psychiatry*, 2011, 4, 375-384.

Clark, D. M. (2016). *Improving access to psychological therapies*. Keynote address presented at the 8th World Congress of Cognitive Behaviour Therapy, Melbourne retrieved from [www.wcbct2016.com.au/](http://www.wcbct2016.com.au/)

Cooper, B. (2009). Strange bedfellows: economics, happiness and mental disorder. *Epidemiologia e Psichiatra Sociale*, 18,3, 208-213.

Davidson, K. (2008). *Cognitive Therapy for Personality Disorders: A guide for Clinicians*. London: Routledge.

Department of Health (2011). *Talking therapies: A four-year plan of action*. Author: United Kingdom. Retrieved from <http://www.iapt.nhs.uk/silo/files/talking-therapies-a-four-year-plan-of-action.pdf>

nhs.uk/silo/files/talking-therapies-a-four-year-plan-of-action.pdf

Dummett, N. & Williams, C. (2008), *Overcoming low mood and depression*. London: Hodder & Arnold.

Farrand, P., Rayson, K., & Lovis, L. (2016). Reflection in low intensity CBT: Challenges and practice-based interventions. In B. Haarhoff & R. Thwaites. *Reflection in CBT* (pp. 141-158). London: Sage.

Farrand, P., Perry, J., & Linsley, S. (2010). Enhancing self-practice/self-reflection (SP/SR) approach to cognitive behaviour training through the use of reflective blogs. *Behavioural and Cognitive Psychotherapy*, 38, 473-477.

Farrand, P., & Woodford, J. (2013). Impact of support on the effectiveness of written cognitive behavioural self-help: A systematic review and meta-analysis of randomised controlled trials. *Clinical Psychology Review*, 33, 182-195.

Farrand, P., & Williams, C. (2010). Assessment in low intensity psychological therapy. In J. Bennett-Levy, D. A. Richards, P. Farrand, H. Christensen, K. M. Griffiths, D. J. Kavanagh, B., .... C. Williams (Eds.). *Oxford guide to low intensity interventions* (pp. 9-103). Oxford: Oxford University Press.

Freeston, M. (2016). *Supervision and competences* (in an IAPT world): Where have we come from? Where are we going? Keynote address presented at 8th World Congress of Cognitive and Behaviour Therapy, Melbourne, retrieved from [www.wcbct.com.au/](http://www.wcbct.com.au/)

Gale, C., & Schröder, T. (2014). Experiences of self-practice/self-reflection in cognitive behavioural therapy: a meta-synthesis of qualitative studies. *Psychology and Psychotherapy: Theory, Research & Practice*, 87, 373-392.

Kroenke, K., Spitzer, R.L., & Williams, J.B.W. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16, 606-613.

Lane, D., & Corrie, S. (2006). *The modern scientist practitioner: A guide to practice in psychology*. Hove, East Sussex: Routledge.

Layard, R. & Centre for Economic Performance: Mental Health Policy Group. (2006). *The depression report: A new deal for depression and anxiety disorders*. London School of Economics. Available at <http://cep.lse.ac.uk/pubs/download/special/depressionreport.pdf>.

Layard, R., Clark, D. M., Knapp, M., & Mayraz, G. (2007). Cost-benefit analysis of psychological therapy. *National Institute Economic Review*, 202, 90-98.

Lewis, A. (2012). Organisations adjusting to change: A discussion of the impact of Improving Psychological Therapies (IAPT)



- National Institute for Clinical Excellence. (2011). *Common mental health disorders: identification and pathways to care. NICE Clinical Guideline 123*. London: National Institute for Health and Clinical Excellence.
- Papworth, M. (2013). Introduction. In M. Papworth, T. Marrinan & B. Martin, *Low intensity cognitive behaviour therapy: a practitioner's guide* (pp. 1-17). London: Sage.
- Persons, J. B. (1989). *Cognitive therapy in practice: A case formulation approach*. New York: Norton & Company.
- Richards, D., & Whyte, M. (2011). *IAPT Reach Out: National programme student materials to support the delivery of training for Psychological Wellbeing Practitioners delivering low intensity intervention*, (3rd edition). London: Rethink.
- Rizq, R. (2012). The ghost in the machine: IAPT and organisational melancholia. *British Journal of Psychotherapy*, 319-335.
- Safran, J. D., & Segal, Z. V. (1990). *Interpersonal process in cognitive therapy*. New York: Basic Books.
- Shafraan, R., Clark, D., Fairburn, C., Arntz, A., Barlow, D., Ehlers, A., .... Wilson, G. (2009). Mind the gap: Improving the dissemination of CBT. *Behaviour Research and Therapy*, 47, 902-909.
- Spitzer, R.L., Kroenke, K., Williams, J.B., & Lowe, B. (2006). A brief measure for assessing generalised anxiety disorder: The GAD-7. *Archives of Internal Medicine*, 166, 1092-1097.
- Telford, J., & Wilson, R. (2010). From classroom to 'shop floor': Challenges faced as a low intensity practitioner. In J. Bennett-Levy, D. A. Richards, P. Farrand, H. Christensen, K. M. Griffiths, D. J. Kavanagh, B., .... C. Williams (Eds.). *Oxford guide to low intensity interventions* (pp. 469-474) Oxford: Oxford University Press.
- Turpin, G., & Wheeler, S. (2011). *IAPT Supervision Guidance*. London: Department of Health.
- Thwaites, R., Cairns, L., Bennett-Levy, J., Johnston, L., Lowrie, R., Robinson, A., .... Perry, H. (2015). Developing metacompetence in low intensity CBT interventions: Evaluating a Self-Practice/Self-Reflection program for experienced low intensity CBT practitioners. *Australian Psychologist*, 50, 311-321.
- Wampold, B. (2001). *The great psychotherapy debate: Models, methods and findings*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Wells, A. (1997). *Cognitive therapy of anxiety disorders*. Chichester: John Wiley & Sons.
- Westbrook, D., Kennerley, H., & Kirk, J. (2011). *An introduction to cognitive behaviour therapy skills and applications* (2nd ed.). London: Sage.
- Whittington, A., & Grey, N. (2014). Mastering metacompetence: the science and art of cognitive behavioural therapy. In A. Whittington, & N. Grey (Eds.). *How to become a more effective CBT therapist: Mastering metacompetence in clinical practice* (pp. 3-14). London: Routledge.
- Williams, C., Farrand, P., & Bennett-Levy, J. (2010). Guided CBT interventions using written materials: Overview. In J. Bennett-Levy, D. A. Richards, P. Farrand, H. Christensen, K. M. Griffiths, D. J. Kavanagh, B., .... C. Williams (Eds.). *Oxford guide to low intensity interventions* (pp. 197-200). Oxford: Oxford University Press.
- World Health Organisation (2016). Programmes, Out of the shadows: making mental health a global development priority. [http://www.who.int/mental\\_health/advocacy/WB\\_event\\_2016/en/en](http://www.who.int/mental_health/advocacy/WB_event_2016/en/en) retrieved 11/11/2016.
- Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema Therapy: A practitioner's guide*. New York: Guilford Press.

Corresponding Author  
 Dr Beverly Haarhoff  
 School of Psychology  
 Massey University  
 Private Bag 102 904  
 North Shore  
 Auckland 0745  
 New Zealand  
 Email: B.A.Haarhoff@massey.ac.nz.