

Introduction to Special Section: Low Intensity CBT in Aotearoa New Zealand

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We are excited to introduce the Low Intensity CBT special section of the Journal. Over the past two decades there have been significant changes to the way in which mental health services are delivered in New Zealand. Many of these changes have been successful and we now live in a society where the population is generally more aware of mental health issues, more likely to seek and expect help, and less likely to stigmatise and exclude those who suffer from mental health problems.

However, despite obvious progress, public demand for more effective, accessible, and affordable psychological interventions continues to grow and there are population groups, such as Māori and Pasifika, who continue to experience relatively high levels of mental health problems. Our children have also been identified as a group needing far more support than is currently offered and, surprisingly, groups identified as having mild to moderate mental health problems also have difficulty in accessing the help they need. Depression is often referred to as the common cold of mental health disorders as the majority the population will have had direct or indirect experience of this condition. The experience of anxiety is also relatively common, especially for women. Less frequently diagnosed than depression, anxiety can seriously affect the quality of life and the productivity of individuals. In New Zealand, 16% of the population will have received a common mental disorder diagnosis at some point in their lives, and within this group Māori and Pasifika people will be over represented. It can further be assumed that many individuals “suffer in silence”, in that they do not seek or receive any help or support.

The Dunedin Multi-Disciplinary Health and Development Study has also confirmed that individuals who

experience mental health problems have more than twice the risk of premature death when compared to the general population (Poulton, Hancox, Milne, Baxter, Scott, & Wilson 2006). Physical health can be compromised by poor health choices made by the mentally ill, such as smoking or using substances to cope with anxiety symptoms or feelings of hopelessness. Socio-economic repercussions such as unemployment, poor housing, social isolation and discrimination are all common effects of mental health problems. Medication is most often prescribed as a first treatment option, and whilst this can be effective in the treatment of depression, the anxiety disorders present a more complex picture, and many individuals experience side effects, find medication compliance difficult, or do not respond to medication. When asked most individuals express a desire for psychological rather than pharmacological intervention (Elliot, 2017). However, the scarcity of specialist practitioners and fiscal restraints make it difficult to provide psychological intervention as first choice.

The Special Section aims to identify pathways which have the potential to lead to a more sustainable and available mental health service by asking if there is anything we can learn from international initiatives? We consider the introduction of low intensity psychological interventions as one possible pathway. Low intensity psychological interventions, most notably those which are CBT based promise the possibility of cost effective and brief evidence-based psychological interventions which can be delivered to a growing population of individuals suffering from mild to moderate mental health problems, such as depression and the anxiety disorders. Low intensity CBT has its roots within the Improving Access to Psychological Therapy initiative (IAPT), developed in England over the past decade. In the English

context, low intensity CBT (LICBT) has been variously described as a “new therapeutic paradigm”, “a revolutionary approach”, having “transformative” potential, and as an agent for the “democratisation of psychotherapy” (Bennett-Levy, Richards, & Farrand, 2010). Under the LICBT banner have come promises of greater client access to evidence based psychotherapies, more choices, less stigmatisation, and greater client control. A primary aim of such an initiative is to mitigate the shortage and high cost of specialist care without compromising access to mental health services. In fact, the promise has been to increase access and thus the general well-being and productivity of the whole population.

The special section will showcase a number of papers aiming to provide both a conceptual overview and some specific illustrations of LICBT in action, drawing on local and international contributions.

The first paper describes the LICBT approach as developed in England as part of the Improving Access to Psychological Therapies initiative (IAPT, 2008). Here we provide a concrete description of the nuts and bolts of the approach, looking at types of intervention and delivery modes. We then go on to examine one of the central pillars of LICBT, namely the recruitment and training of a new “low intensity” mental health practitioner category called “the Psychological Wellbeing Practitioner” (PWP). The role of the PWP will be contrasted with that of the High Intensity Practitioner which is a practitioner model more in line with what we have come to expect in New Zealand. Paper two, as a companion paper to the first, is an overview of the historical and current status of the New Zealand mental health service delivery model. To provide context, this paper details the ways in which access to,

and delivery of psychological services have been structured, identifying a series of four progressive waves. The paper concludes with a focus on the future. Here we introduce three recommendations which include the training of a new workforce specialising in the delivery of LICBT psychological interventions and an increased utilisation of new ways of delivery which utilise new technologies. The next three papers are empirical research studies completed in New Zealand. The studies describe LICBT programmes delivered to individuals in different contexts. The first examines the applicability of a CBT programme for Asian students studying in NZ, the second looks at 'face to face' and telephone delivery of a LICBT programme, and the third paper has a case study approach examining change during therapy through the application of routine outcome assessments. The last two papers, papers six and seven, are from overseas contributors, who are researchers intimately involved with the IAPT programme in the training, supervision, and management of Psychological Wellbeing Practitioners and in the development of low intensity CBT interventions. Paper six describes a behavioural activation programme for patients with dementia, and the final paper considers self-practice/self-reflection as a novel experiential training strategy in the context of improving therapeutic empathy in Low Intensity practitioners.

We hope that this series of papers will stimulate discussion in the New Zealand mental health sector regarding the empirically-based research that supports access to services for people experiencing mild to moderate mental health problems.

References

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