Low Intensity Cognitive Behaviour Therapy

A Practitioner's Guide

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Introduction

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Learning objectives

- To understand the fundamental principles of cognitive behaviour therapy (CBT) and low intensity cognitive behaviour therapy (LICBT).
- To know the historical context of the development of CBT and LICBT.
- To be aware of systems of stepped and matched care that support the practice of LICBT.
- To have knowledge of the other aspects of service delivery (for example, service promotion and self-referral), which are required to maximise the impact of the approach.
- To understand the economic argument which justified the English LICBT (Improving Access to Psychological Therapies, IAPT) scheme, and to be aware of the effectiveness of LICBT.

Introduction

The 'core mission' of this book is to teach the reader how to perform low intensity cognitive behavioural therapy (LICBT). This is a form of CBT that is used to treat mild to moderate, common mental health problems over a shorter length of contact, through

the use of therapy vehicles (such as supported self-help). More latterly it has been expanded to help clients to cope with long-term physical health conditions as well. However, before I turn to this important and fascinating topic, by way of an introduction I look at the varied contexts in which the approach has grown. These contexts have both enabled the development of the approach and are required to support its practice. These might be broadly described as *historical* (LICBT's origins), *service-related* (the arrangement of healthcare services which support LICBT) and *political* (the economic and political arguments that have driven the development of LICBT). To overview these, this chapter first examines the principles of CBT and LICBT, and then two of the psychotherapeutic approaches that have been instrumental in the development of CBT, the stepped care model of service delivery and latterly the English Improving Access to Psychological Therapies (IAPT) programme.

Cognitive behavioural therapy

The CBT approach assumes that emotions, behaviours and physical symptoms (which are core components of common psychological disorders) are influenced by thoughts, beliefs and images that exist in individuals' minds. These mental processes are termed 'cognitions'.

A classic example of this process in action is illustrated by the following situation: imagine that you are walking along a street and you notice that an acquaintance is approaching, walking towards you but on the other side of the street. You try to catch their attention but, rather than wave back, this person carries on walking without acknowledging you, with their head remaining bowed down. Let us suppose the thought then goes through your mind: 'What have I done to upset them, why doesn't this person like me?' These cognitions might naturally cause you to become worried about your relationship with that person and more generally about how others perceive you. You might later also experience some physical symptoms that commonly accompany worry such as difficulty sleeping and restlessness while the matter plays on your mind. Now, let us imagine an alternative cognitive response to the situation. In this instance, you think instead: 'They seem preoccupied, I wonder what is concerning them?' This line of thought is likely to have impacted less on your mood because it is enquiring about their situation rather than reflecting negatively on your own. As such, it will probably lead to a different course of action, perhaps contacting the acquaintance to check if they are in any difficulty.

The CBT approach provides a framework for understanding how individuals' interpretations of events may lead to the development and maintenance of psychological disorders (such as depression and anxiety). CBT treatment then involves the use of techniques to change dysfunctional patterns of cognition and behaviour that are

central to such psychological difficulties. This approach emerged in the 1950s and 1960s, both arising out of 'behavioural approaches' that were popular at the time and as a reaction to 'psychoanalytic psychotherapy'. Before investigating CBT further, I first explore these therapeutic approaches to help us to understand its roots.

Psychoanalytic psychotherapy

Psychoanalytic psychotherapy has been in existence for over a century and, over this time, it has developed into numerous models of the mind and human nature. Therefore, you should bear in mind that below is a brief, basic summary of one (the Freudian) model that is informed by Atkinson et al. (1990) and also Smith (1995). The psychoanalytic approach assumes that various tensions or conflicts exist within an individual's psychological 'make-up' or personality. These conflicts arise as a result of competing demands made by three different components that exist in the person's mind. These are termed: *id*, *ego* and *super-ego*. The id develops earliest in life and consists of our basic impulses, motivations and drives (for example, the need to eat and to gain sensual pleasure). Later, as infants, we learn that these impulses cannot always be satisfied immediately, and we develop another element or aspect to our personality: the ego. This is essentially the manager of the id. It juggles the competing demands of the id, the real world and also the super-ego. The super-ego consists of the values and morals of society that are taught to the child by their parents and other adults. This is the part of the mind that rewards the individual for being good and punishes them for being bad.

Sigmund Freud (1856–1939) was the principal originator of this approach (in the late 19th century). He proposed that some difficulties emerged from tensions or conflicts between these elements. He also pictured the mind as having a similarity to an iceberg. Most of the iceberg is not visible because it is below the water's surface. Similarly, much of the activity of the human mind occurs below the surface of our consciousness, therefore occurring on an unconscious level. When there is a severe conflict, the ego can protect the individual by pushing it into the unconscious. So, for instance, an anxiety disorder might be fuelled by the presence of unconscious, unacceptable or dangerous impulses that are kept in check (or repressed) because they might impact upon a person's self-esteem or relationships. However, this is not a permanent solution and this unconscious material exerts pressure. At times this finds expression through irrational behaviour, dreams and possibly psychological difficulties if the ego is unable to sufficiently manage the situation.

Psychoanalysts seek to help their clients by bringing their conflicts into their awareness, ideally transforming symptoms into insights. They attempt to uncover the unconscious conflicts through use of techniques that facilitate their expression. These include:

- free association – unconscious conflicts can be revealed by the client saying what comes into their mind without any conscious editing;
- dream analysis – dreams are considered to contain unconscious desires in a disguised form;
- analysis of 'transference' responses – the client's unconscious feelings towards the therapist mirror childhood responses to parents that can explain the origins of conflicts; and
- interpretation – the client is helped to develop insight by the analyst feeding back or interpreting the understanding that they have learned about the client's resistance and motivations.

The process of psychoanalysis is lengthy and intense. It traditionally involves therapy sessions for several times a week, for at least a year and often longer. Its protagonists believe that, as unconscious material is brought to light and understood, symptoms are dissipated.

In understanding the historical development of CBT, I draw on Morrey (1995) as well as France and Robson (1997). CBT pioneers such as Albert Ellis (1913–2007) and Aaron Beck (1921–) were originally psychoanalytic psychotherapists who, in the 1950s and 1960s, came to understand that there were radically different ways to make sense of clients' psychological difficulties. Another key individual is the clinical psychologist, George Kelly (1905–1967). He also developed an approach in 1955 that emphasised certain principles that were common to CBT. I focus below on Beck's model because historically it has been the most popular form of CBT practised in the UK (Morrey, 1995). However, it needs to be noted that there have been other contemporary CBT approaches that remain popular (for instance, Rational–Emotive Therapy). There have also been important developments in the field of CBT in recent years (such as mindfulness-based CBT).

Beck originally sought to experimentally investigate the psychoanalytic proposition that depression was fuelled by repressed hostility. He did this by surveying the dream content of depressed individuals. His results contradicted this hypothesis and he found that their dreams were characterised by pessimism rather than anger. Likewise, within his therapy sessions, when clients were asked to free associate, the content of this process was not always of relevance to what was hypothesised to be the roots of their difficulties. Rather, their thoughts revolved around more immediate reactions to their situation, such as worrying about how Beck would judge a comment that they had made. Upon further investigation, he found that many depressed clients reported experiencing these types of thoughts and that they seemed to occur as much in their everyday lives as in the therapy session. He labelled these as 'automatic thoughts' because they occurred rapidly and fleetingly without conscious prompting. While some of the thoughts were plausible, many seemed irrational or without basis, yet at the moment they occurred they were accepted unquestioningly by the client. They were often negative in nature and hence became known as *negative automatic thoughts*.

Beck came to see these patterns of thinking as a distorted lens through which clients saw both themselves and their surroundings. He helped his clients to explore a method of correcting these patterns by challenging these thoughts with questions such as: 'What is the evidence for … [their interpretation of an issue or situation]?' and 'Is there an alternative explanation?' He found that, as clients used this technique to develop an alternative perspective, their difficulties rapidly improved – these observations forming the early building blocks of CBT (Beck, 1976).

Exercise 1.1 The origins and basics of CBT

Learn about the fundamentals of CBT by watching these internet clips:

- Beck describes the origins of CBT: www.youtube.com/watch?v=g879lJmAQCM&feature=related.
- Beck's psychologist daughter (Judith) talks about the basics of CBT: www.youtube.com/watch?v=45U1F7cDH5k.
- David Clark (an eminent UK clinical psychologist) explains the principles of CBT in a way that a client can understand: www.youtube.com/watch?v=bvH9kUUmGog.
- A client describes her experience of receiving CBT: www.youtube.com/watch?v=GVX4iVXtT-o&feature=relmfu.

Behaviour therapy

'Behaviour therapy' refers to a number of different therapeutic approaches based on the principles of learning, which were established in the early to mid-twentieth century. Learning theory pioneers such as Ivan Pavlov (1849–1936) and Burrhus Skinner (1904–1990) found that animals and humans alike learn in two primary ways. Together, these form the building blocks of learning (Atkinson et al., 1990). The first of these is termed *classical conditioning* and refers to learning that one event will follow another. For example, a baby learns that milk will follow from the sight of a breast. In his classic experiment, Pavlov retrained a dog's salivation response. Naturally, when a dog sees food (the food in this context is termed an 'unconditioned stimulus'), it salivates (an 'unconditioned response' to this stimulus because it is a natural one). However, let us suppose a bell (a 'neutral stimulus') is also rung each time that the food is presented. Over time, the dog will associate the bell with the food and then salivate to the sound of the bell alone (this then becomes a 'conditioned response' to the 'conditioned stimulus' – the bell).

The second form of learning is termed *operant conditioning* and refers to learning that a behaviour will be followed by a consequence. For example, a child learns that hitting a sibling will result in disapproval from a parent. Skinner found that, if an animal is given a reward (such as food) after performing a behaviour (like pressing a lever), the frequency of that behaviour increases dramatically. In this way, rewards (or 'reinforcements') increase the rate of behaviour occurrence. There are two types of reinforcement: positive and negative. Positive reinforcement occurs when a behaviour increases or is strengthened following the provision of a satisfying stimulus. So, a person might work harder or take on more duties if they are paid more. Negative reinforcement occurs when a behaviour increases or is strengthened as the result of taking away an unpleasant stimulus. In this way, a person might learn to improve poor work performance in order to avoid disapproval from their manager or take aspirin to remove a headache. Punishment differs from reinforcement in that it consists of providing an unpleasant stimulus after a behaviour (for example, slapping a child for throwing some food). This will tend to suppress the behaviour. However, as punishment fails to convey an appropriate alternative behaviour, its effects can be unpredictable. In addition, it can instil fear and aggression, and so for these reasons it is seen as a less effective form of learning. Later, psychologists also identified learning that occurs through observing others (Bandura, 1973).

Aspects of the development and maintenance of clinical difficulties can be understood in terms of learning theory. For example, a phobia might be developed through classical conditioning. This was demonstrated by John Watson (1878–1958) when he introduced a nine-month-old baby (Little Albert) to a number of objects (including a rat). Initially, Albert did not exhibit fear in response to these. However, as Albert was subsequently introduced to these objects, a loud and frightening sound was made. Consequently, Albert made a link between the conditioned stimulus (the rat) and the conditioned response (fear), illustrating a mechanism for the development of a phobia. Clients sometimes report similar origins to their own phobias. A phobia of public transport might develop after experiencing an extremely humiliating experience on a bus such as involuntary defecation. Fear may then be maintained by operant conditioning as the avoidance of aversive states is reinforced through avoidance of the feared stimulus (Mowrer, 1947). This can be illustrated with the example given above where, by avoiding public transport, the person does not experience the high anxiety associated with this situation. This encourages them to continue to avoid public transport in the future.

Exercise 1.2 The application of learning theory

A mother is travelling on a bus with her 4-year-old son. The son has a temper tantrum because he is bored and wants to go home to play with his toys. The mother, feeling

embarrassed, removes her son from the bus, abandons her trip and takes him home. Which behaviour is being reinforced? What form of reinforcement is being used?

When the mother and child get home, the child quietly plays with his toys. At this point, the mother shouts at her son for embarrassing her earlier. Despite the mother's intentions, which behaviour is actually being punished at that point?

Is the mother's behaviour helping the child? If not, give some thought to what responses would be more helpful for him.

Behaviour therapy uses the principles of learning theory in order to help people to overcome their psychological problems. For instance, the treatment of phobias involves a process of deconditioning. This approach was termed 'systematic desensitisation' (Wolpe, 1969) and has similarities to 'graded exposure'. This involves substituting a response to a feared stimulus that is incompatible with anxiety, in this case relaxation. The client is taught skills that allow them to relax, prior to them being introduced to the anxiety-provoking stimulus. The client's task is then to relax while being exposed to the stimuli, thus breaking the relationship between the object/situation and fear. Exposure is graded in that the process starts with a stimulus that provokes a lesser degree of anxiety such as a picture of a cartoon rat rather than a live one. Then, after anxiety lessens through repeated exposure to this stimulus, increasingly challenging ones are then confronted (see Chapter 10 for details of graded exposure).

Cognitive therapy practitioners originally emphasised the use of cognitive techniques to alleviate distress, but then later integrated behavioural perspectives to form CBT. For example, Clark's (1986) approach to the treatment of panic disorder uses both cognitive techniques (identifying the thoughts that drive anxiety, then challenging these thoughts and substituting them with more functional alternatives) and behavioural ones (using behavioural experiments to disconfirm panic-related thoughts and exposure to confront avoided stimuli; see Chapter 10 for details regarding the theory and implementation of these techniques). However, it should be noted that similar developments also evolved from another source in that behaviour therapists such as Martin Seligman (1942–) began to incorporate cognitive mechanisms into their approach in the mid-1970s (France & Robson, 1997).

Key features of CBT

Having examined the fundamental roots of CBT, I now turn our attention to the key features of the approach. A number of texts have overviewed CBT features (for instance, Blenkiron, 2010; France & Robson, 1997; Kennerley et al., 2017) and I draw on these below.

First, whereas psychoanalytic psychotherapy takes the view that difficulties often have their roots in past conflicts and unconscious processes, CBT's focus is more on what is happening for the client in the present. In particular, it is concerned about the relationship between their symptoms, together with the triggers, modifiers and cycles that maintain them. This is not to say that CBT ignores the influence of past experience; rather, the focus of treatment tends to be on how problems are being maintained in the present.

Second, the CBT approach assumes that the different kinds of symptoms interact with each other. These occur over the domains of cognition, behaviour, emotion and physical/autonomic. In the example I provided earlier in the chapter (walking along the street), cognition ('I wonder what is concerning them?') is seen to impact upon the emotion (anxiety), which then affects behaviour (telephoning the friend). However, other psychological 'chain reactions' are possible. For instance, physical symptoms, such as an increased heart rate, may lead to the thought 'I'm having a heart attack,' which may influence the person's behaviour: they may call emergency services or withdraw from the situation. The CBT approach investigates and defines the relationships between these phenomena through use of a formulation. This is a kind of map of these relationships (see Chapter 3). CBT helps clients to work on their problems and goals by allowing them to break these patterns and substitute them with more helpful alternatives.

Third, CBT is defined by an ethos of 'operationalism' and scientific study. This means that the CBT approach is defined (or operationalised) relatively precisely to allow practitioners to be trained to adhere to structured (or manualised) approaches to deliver the therapy (the LICBT interview protocols are outlined in Chapter 5). An example of a CBT manual for the treatment of depression in adolescents is available at: https://trialweb.dcri.duke.edu/tads/tad/manuals/TADS_CBT.pdf. Other manuals are published in book form, for example Beck et al. (1979). These typically outline key topics such as the length and phases of treatment, the structure of the sessions, how to understand the disorder in question and explain the relevant concepts to clients, as well as how to implement the CBT treatment techniques. CBT is also based upon and modified according to the results of scientific investigation, rather than being slavishly derived from theory. In this way, research is used to identify which methods of treatment are the most effective. This ethos is also fundamental to clinical practice, where both practitioner and client must be willing to test out and experiment with ideas. The term *collaborative empiricism* is used to describe this process.

Fourth, CBT is an approach that is characterised by high levels of collaboration between the practitioner and the client. It requires both parties to work together, with initially the practitioner sharing the principles of CBT with the client, and the client sharing the details of their difficulties with the practitioner. Practitioner and client then work together to allow the client to achieve their goals, the client taking increasing responsibility for change as the therapy progresses. The practitioner aims to generally avoid instructing the client. Rather, the aim is to allow them to discover the relationship

between their symptoms and the solutions to their difficulties through guided discovery. This is achieved through behavioural experiments and Socratic questioning. Socrates (470–399 BC) was a Greek philosopher from ancient times who resisted instructing or arguing, alternatively asking questions as if he were a naive enquirer. Through his careful questioning, eventually his students and philosophical opponents would be obliged to recognise the weakness of their arguments. Socrates saw his role as helping individuals to 'give birth' to understanding as a midwife helps in the delivery of a child. CBT practitioners have adopted some of the principles of this approach: 'Through sensitive questioning, clients are encouraged to use what they know, to discover alternative views and solutions for themselves, rather than the therapist suggesting them' (Westbrook et al., 2011: 138).

Finally, the CBT approach is structured. For example, it is 'time limited'. This means that clients are offered a set number of sessions, the number of which will depend upon the difficulties that they experience. Other forms of structure include the setting of an agenda with the client at the beginning of each session. This details the topics that the practitioner and client will cover within the session. Clients are also given homework tasks to complete between sessions that can form a vital part of the change process. In the assessment stage, homework might involve completing diaries that help the practitioner and client to understand the problem better. In the treatment stage, homework consists of tasks that aim to highlight and change unhelpful patterns (see Chapter 10). An important aim of this structured approach is to maximise learning through the use of recording and measuring. In this way, the client is enabled to become more aware of their pattern of symptoms and the factors that affect these. This can also help to provide evidence of progress that can be used to boost motivation in future tasks. Similarly, the therapy is evaluated by repeating standardised measures with clients at regular intervals (see Chapter 3). This allows both the practitioner and client to determine the effectiveness of the treatment. It gives practitioners the chance to reflect, both individually and through supervision, upon the influences on clients' progress. It also enables CBT services to demonstrate their effectiveness to managers and service commissioners.

Key features of LICBT

Low intensity CBT has emerged to become a mainstay of English adult community mental healthcare services. This followed the implementation of the government's Improving Access to Psychological Therapies programme (see below). However, developments in the approach are also occurring in many other countries such as Australia, Belgium, Canada, Germany, Holland, Italy, Kenya, New Zealand, Norway, Pakistan, Scotland, Sweden, the USA and Uganda (Bennett-Levy et al., 2010b; European Association for Behavioural and Cognitive Therapies, n.d.; Massey University, 2016;

Mental Health Innovation Network, 2015; NHS Education for Scotland, n.d.). The terminology of high intensity CBT (HICBT) and LICBT is linked to the stepped care model of service delivery (see below). LICBT has evolved from the traditional or high intensity model of CBT therapy outlined above, which is described in many key texts (for instance, Beck et al., 1979). It shares HICBT's principles in that it is present-focused, views difficulties in terms of interacting clusters of symptoms, is based on a scientific approach, and is also both collaborative and structured. However, it is distinct in terms of its use of differing forms of therapy delivery. As such, the following additional principles both apply to and define the approach.

A first tenet of LICBT is one of efficiency. LICBT is a high-volume approach that enables a practitioner to expertly help many more clients than can be reached with a high intensity format. This is achieved through the brevity of the therapy duration (typically six to eight weekly appointments) and the length of each session (about 30 minutes), or through delivering an intervention to many clients simultaneously (via large group formats; see White, 2010a).

A second principle is associated with the use of specific vehicles to facilitate the delivery of CBT. These vehicles are instrumental in allowing the practitioner to administer an intervention at an accelerated pace. These typically include self-help materials, but also large format groups and computerised CBT programs. Naturally, to be in keeping with the scientific approach, these materials should be based on established CBT techniques and ideally have a strong evidence base (see Chapter 2).

A final LICBT principle is one of early access to services. For clients to make best use of this form of CBT and to maximise service effectiveness, individuals need to be able to access services early on in the development of their mental health difficulties. At this stage, a relatively small amount of therapeutic input may significantly shift the trajectory of the client's problems. As time goes by, problems may become entrenched and chronic in nature. Negative cycles involved in the development and maintenance of difficulties then become embedded within a person's lifestyle which can, in time, reduce the client's ability to respond quickly to a low intensity approach. As such, integral to the LICBT approach are mechanisms that increase early access to services such as self-referral systems and the promotion of services within communities. Additionally, for those with more chronic or severe difficulties, there is a need for HICBT and LICBT services to be closely coordinated. It is this service delivery context that I consider next.

LICBT and service delivery: stepped care

I have introduced both HICBT and LICBT, and now take a step further back from the client to consider the broader perspective of how services should be structured to allow these forms of CBT to be delivered. This is done via the *stepped care* approach.

LICBT is an effective approach for most mild to moderate presentations of common mental health problems. However, like any psychotherapeutic approach, it is not a universal panacea. Because of this, it is important that LICBT practitioners are situated within a broader mental healthcare network to allow non-responding clients to be directed to other treatments. The recommended method of coordinating these services is a stepped care system (National Institute for Health and Clinical Excellence, NICE, 2011a). Within stepped care, clients usually move through treatments that are based on different 'steps' (or intervention levels) until their needs are met. These interventions increase in intensity (and often cost) over progression through these steps. The system is designed to be self-correcting in that the client's reaction to treatment is monitored and individuals are 'stepped up' to the next level if they do not respond to the treatment situated in their current step. Thus, some individuals will only experience one step, whereas others may experience different components of the service that are based on other steps.

Let us consider a simple example of a stepped care system for acute migraine headaches. Lipton et al. (2000) detail a two-layer, stepped care model for pharmacological treatment. The first step involves the use of asprin (800–1000 mg) plus metoclopramide (20 mg). Those patients who did not have a beneficial response to this treatment are then to be offered a Step 2 treatment of zolmitriptan (2.5 mg), which is more expensive and which has a risk of more significant adverse effects. In this way, clients are initially offered a less expensive treatment, before being offered a more targeted one, which, for many individuals, will be unnecessary. A variant of the stepped care model that is also described in Lipton et al. (2000), is 'matched' or 'stratified' care. Here, rather than work up the steps until treatment is successful, attempts are made to match individuals at the outset to the step that is best suited to their needs. This will be based mainly on the individual's particular problem presentation (in this instance the severity of their headaches).

Exercise 1.3 The experience of stepped care

Either on your own or in a small group, pick an activity that is commonly learned or developed through self-help (such as car maintenance or cookery). If possible, individuals in a group should pick different activities. Do not pick psychology or therapy-related ones! Now consider whether you would: (a) prefer to use, (b) use at a push or (c) never use self-help as a vehicle to learn this. If the latter, why not? If you are in a group, through discussion, begin to understand differences between individuals'

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preferences (for example, is this due to a lack of confidence, differences in learning style or prior experience?). Attempt to pinpoint and categorise factors that feed into this variability within the group. If you are doing the exercise individually, consider this through self-reflection.

Now consider a stepped care model for help with learning this activity. This consists of: Step 1 where learning is entirely self-administered (self-taught through use of book, audio or video instruction); if this is ineffective, Step 2 is learning through minimal professional contact (self-taught but expert support is available to monitor and assist); if this is also ineffective, finally Step 3 consists of intensive, expert tutoring. What would be the effects of this stepped care approach on your own experience? What might the positive effects be? What are any potential negative effects? What factors lie behind these?

CBT has been considered to be an ideal candidate for stepped care for two reasons (Bower & Gilbody, 2005). First, the infrastructure exists for it to be delivered at differing 'intensities'. Second, it has been highlighted as one of the psychotherapies of choice for a number of common mental health disorders (NICE, 2005, 2009, 2011a, 2011b).

To illustrate, a stepped care treatment model for depression (which includes only the CBT approaches) is listed in Table 1.1 (based on NICE, 2009). Here, the initial step is likely to occur in the community at the practice of the client's primary care physician (PCP), but also possibly in other general healthcare settings. At Step 1, PCPs are alert to possible illness in their patients, for example, offering screening for high-risk groups such as those who have previously experienced depression or who are suffering with significant physical health problems. Where mild to moderate depression is identified, LICBT can be initially offered (Step 2) to help with the client's difficulties, with medication being offered only to those who do not then respond to LICBT (thus there is a form of micro-stepped care that operates within Step 2).

Step 3 consists of treatments to help those with moderate to severe depression, as well as those who have not responded to Step 2. These individuals will usually be offered antidepressant medications prior to, or in conjunction with, a psychological approach. This will be HICBT. More complex forms of depression such as treatment-resistant, recurrent, atypical and psychotic depression will need to be treated by specialists. In the UK these are usually based in community teams at Step 4. Finally, Step 5 is for those who require inpatient care, for instance owing to the severity of their disorder, suicide risk or concerns with self-care and neglect. This recommended stepped care system is, strictly speaking, a mixed stepped and stratified model in that clients may enter

Table 1.1 Recommended stepped care system for CBT approaches for the treatment of depression (based on NICE, 2009)

Step	Location	Service	Intervention	Responsive conditions	Possible outcomes
Step 1	Primary care physician's clinic	Primary care physician or nurse	Recognition, assessment, CBT-based psycho-education, monitoring	Mild, self-limiting	Client recovers or is stepped up
Step 2	Primary care mental health team	LICBT practitioner	LICBT, including guided self-help and CCBT	Mild to moderate	Client responds or is stepped up
Step 3	Primary care mental health team	HICBT practitioner	HICBT	Moderate to severe	Client responds or is stepped up
Step 4	Mental health specialists, including community mental health teams and crisis assessment teams (CATs)	Multidisciplinary	Treatment usually incorporates CBT	Treatment-resistant, recurrent, atypical or psychotic depression and those at significant risk	Client responds or is stepped up
Step 5	Inpatient care, CATs			Risk to life, severe self-neglect	

Step 3 directly, depending on both their preference and how they have responded to treatments previously, and also Step 4 if they are assessed as requiring specialist input. This overcomes a criticism that, for some clients, a stepped care system might contribute to feelings of hopelessness where the system necessitates that they endure treatment failures prior to them eventually getting their needs met.

The National Institute of Health and Clinical Excellence (NICE, 2011a) recommends that common mental health problems are treated within a stepped care process. This model incorporates guidance for a number of disorders and focuses on Steps 1–3 where care is offered in the community by mental health professionals. Readers are referred to this reference, but the interventions and services associated with these steps are broadly the same as indicated in Table 1.1. However, how the model is implemented in practice will depend on service- (local networks) and client-related factors (such as client preference and motivation).

As important asides, it should be noted that LICBT practitioners cannot function without adequate supervision (and this is covered in Chapter 17) and so the provision of this supervision needs to be in place. Likewise, planning associated with information technology (IT) support needs to be undertaken prior to the setting up of new services.

Exercise 1.4 Getting to know stepped care

The stepped care systems outlined by NICE (www.nice.org.uk) are based on the best evidence available at the time that they were written. Review the stepped care systems that they propose for depression (NICE, 2009), anxiety (NICE, 2011b) and obsessive compulsive disorder or OCD (NICE, 2005). See how they relate to the general model for common adult mental health problems proposed by NICE (2011a).

Improving Access to Psychological Therapies

A number of factors persuaded the UK Government to invest in a massive spend-to-save model that principally consisted of new, nationwide, CBT, stepped care services in England. LICBT has now become firmly established in English healthcare following the introduction of a new profession of psychological wellbeing practitioners (PWPs) who are employed to deliver this approach. These professionals are the main providers of psychological therapies for Step 2 of the stepped care model and, in so doing, offer the bulk of psychological care to adults experiencing common mental health problems in England. The programme was called 'Improving Access to Psychological Therapies' (IAPT) and started with two pilot sites in 2006. Following this, 11 pathfinder sites were funded before the process of rolling out services across the nation started in 2008.

The precipitant to this scheme was a powerful argument outlined by a group of economists, health service managers and mental health professionals (Layard et al., 2006). This was constructed from several points:

- Mental illness represents an enormous cost to the nation, with some 40 per cent of all disability resulting from mental illness and one in six individuals in society experiencing anxiety or depression.
- There is a large human cost to those suffering with these forms of difficulty and, at that point in time, only 2 per cent of National Health Service (NHS) expenditure was directed towards treatments for anxiety and depression.

- The financial cost to the government in terms of loss of work output was estimated at £12 billion (this figure was later revised to £17 billion).
- However, with the introduction of the proposed IAPT scheme, the projected cost to treat these individuals was estimated to be as little as £0.6 billion.

This was based on a forecast of IAPT delivering a 50 per cent success rate, together with a reduced chance of relapse (in comparison to pharmacological treatment). In this way, it was expected that the IAPT scheme would more than pay for itself, even without taking into account the knock-on benefits of both reduced medication and other healthcare costs.

It was planned that IAPT services should be delivered via the stepped care model proposed by NICE, IAPT practitioners being initially trained in HICBT or LICBT (although other evidence-based therapies were later included). These individuals would work together in teams that would include other individuals such as senior therapists who would be available to provide supervision and other professionals (such as employment advisers) who could help individuals with important practical matters such as clients' return to work. Clients would also be able to self-refer themselves into services that would be delivered close to their homes in community venues or at home via telephone support. The outcomes of services would be monitored (which is in keeping with the scientific perspective of the CBT approach, see above) to demonstrate the effectiveness of the scheme.

At the time of its proposal, the scheme provoked debate within the clinical psychology profession. Critics raised some issues that were based primarily on misconceptions (Clark et al., 2009a). Despite this, one of the issues is worth noting. In many instances, psychological distress is caused and maintained by social and economic factors that CBT alone cannot address. For example, it is well established that levels of deprivation influence mental and physical health. A male working in an unskilled manual job is likely to live almost eight years less than one working as a professional. Similarly, those unemployed or insecurely employed are over twice as likely to experience poor mental health (Wilkinson & Marmot, 2003). Likewise, those with an absence of social support are more likely to experience psychological difficulties (for example, Brown & Harris, 1978).

While CBT cannot be an answer to all of these problems, within IAPT there is some attempt to address individuals' social and economic needs through the inclusion of employment advisers in the matrix of services. Additionally, a vital part of the wellbeing practitioners' role within the scheme is liaison with, and signposting to, agencies delivering occupational and other forms of support (such as debt management). This entails the use of some generic liaison skills and decision-making options which will be locally determined (see Chapter 16).

Exercise 1.5 Developing a community resource portfolio

The community resource portfolio (CRP) is an invaluable and evolving tool that allows the practitioner to help clients to access relevant community resources to meet their needs. These meet their social, community, education, vocational and some clinical needs. It is usually an electronic resource that can be kept on laptops or memory sticks alongside an electronic collection of CBT-based self-help materials. This facilitates the transportation of the CRP between community venues. Relevant segments of it are printed off for clients or emailed to them as appropriate. This exercise involves constructing a CRP for yourself or your service.

This portfolio will contain the relevant sections:

- *Employment*: Different forms of vocation training from employment and voluntary services; opportunities for voluntary experience; and agencies that will facilitate and support individuals in ongoing training, and in maintaining their voluntary or paid employment.
- *Welfare benefits*: Information about the level of benefits that clients can receive when they are not working; information about 'therapeutic work' that individuals can undertake while remaining on welfare benefits, as well as resources and supports that will facilitate individuals in claiming and knowing their entitlement.
- *Clinical*: Relevant clinical services and supports for individuals, including both statutory and non-statutory resources.
- *Educational*: Leisure and formal courses available at local schools, colleges and community venues.
- *Social*: Hobby, club and leisure activities; other means of socially enriching lifestyle (for example, friendship and dating resources).
- *Other*: Helpful resources such as the Citizens Advice Bureau, which straddle several of these categories.

There are various sources of information for your CRP. These include: the internet, contacts listed in self-help books, existing resource directories that are published by other services and feedback from colleagues as well as clients. It may also be useful to contact other organisations for further information and, if possible, to visit them.

The IAPT programme received government support and Clark et al. (2009b) reported on the performance of the two IAPT pilot sites. One of these (Doncaster) is of particular interest as it had a marked emphasis on low intensity work (particularly guided

self-help). Clients were offered therapeutic contact on average 21 days following referral and they received an average of 4.9 sessions. Only 3.8 per cent of clients seen at Step 2 were subsequently stepped up to Step 3. Of the clients who received treatment, 56 per cent had recovered at the time that they were discharged from the service. Of all treated clients, 50 per cent maintained recovery at ten months follow-up. The expected number of clients had returned to work and, as predicted by the model, higher recovery rates were observed in those who had experienced difficulties for six months or less. In this way, the pilot site evaluation report found LICBT to be a highly effective approach. Consequently, the IAPT scheme was rolled out across England.

Since the first edition of this book, there have been two significant developments in the field which are reflected in some of the additional content in this edition. First, the role of PWPs has been broadened to include a more general knowledge of behaviour change (UCL, n.d.). As such, in this edition we have included a new chapter on behaviour change and engagement that is in keeping with this aspect of the new English PWP training curriculum (Chapter 7). Second, the PWP role within the IAPT programme has expanded to include supporting those with long-term physical health conditions (LTCs) by linking PWPs into physical healthcare systems. This is because around two-thirds of individuals with LTCs also experience mental health difficulties which increase the care costs for these individuals by about 45 per cent (Naylor et al., 2012; NHS England, n.d.a). With this in mind, we have also included a new chapter on working with LTCs in this edition (Chapter 14).

Summary

- LICBT is defined by a number of key principles. It is a high-volume approach that uses therapy 'vehicles' to deliver treatment and it assumes that domains of symptoms interact with each other. Additionally, it is a more present-focused, scientific/operationalised approach that involves high levels of collaboration between practitioner and client.
- A national service evaluation has demonstrated that it is an effective approach for the treatment of many mild to moderate, common mental health problems (Clark et al., 2009b). The latest evolution of the national programme also integrates it into the management of long-term conditions within primary care.
- The approach is also seen to be cost-effective. According to economic modelling, access to treatment is much less expensive than the impact of not offering an intervention in terms of the costs of loss of work output (Layard et al., 2006).
- A 'stepped care' matrix of appropriate services needs to be in place to support LICBT. This includes HICBT practitioners as well as operational links with other services (such as crisis services). Other workers who can provide support in regard to economic and

social issues (for example, employment advisers) also need to be included in this system.
- Finally, efforts also need to be made to promote services within communities and to other health professionals, as new services will require changes in referral behaviour and the approach is facilitated by early access to services.

Further reading and activities

At the end of each chapter, we provide some options for you to learn more about the subject:

- The background to the IAPT programme is detailed at: cep.lse.ac.uk/textonly/research/mentalhealth/DEPRESSION_REPORT_LAYARD2.pdf.
- Discover how an example of a computerised client management system can be used to support LICBT services by exploring: www.iaptus.co.uk/ or www.pc-mis.co.uk/.
- Learn more about the impact that work and the environment has on mental health by looking at Wilkinson and Marmot's (2003) paper, which is available from: www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf.