

**Improving access and treatment effectiveness using low intensity
cognitive behavioural therapy for mild to moderate level mental
health disorders, including medically unexplained symptoms, in
Northern Ireland.**

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Volume 1 of 2

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appendices, and references or bibliography.

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Finally, sincere thanks to every person who participated in this project, particularly the clients and trainee PWPs. I would like to acknowledge the bravery of those living with depression and anxiety. May everyone have hope, and may everyone have access to the help they deserve.

Dedication

Remembering my beautiful friend,

Gabrielle Durkan,

This is for you.

Summary and rationale

The main aim of the current thesis was to evaluate a new psychological therapy service in Northern Ireland (NI), which is designed to treat adults with mild to moderate level mental health difficulties, primarily depression and anxiety. The particular mental health service model which was implemented and subsequently evaluated in the current study, was designed and delivered in accordance with the English “Improving Access to Psychological Therapies” (IAPT) service model. This service facilitates the delivery of low intensity cognitive behavioural therapy (LICBT) by psychological wellbeing practitioners (PWPs).

Chapter 1 provided detailed background information on the English IAPT initiative and a detailed overview of mental health and services in NI. The key papers presented in the introductory chapter clarify the framework for the current project. Specifically the rationale for the widespread implementation of IAPT was discussed with a focus on clinical and economic arguments. Important reports in relation to mental health in NI highlighted the key issues there. The justification for evaluating an IAPT type service model in NI was thereby strongly clarified within the first chapter.

The methodologies employed in the main evaluation were the primary focus of Chapter 2. One of the primary objectives of the research was to examine the effectiveness of the new LICBT service in terms of the reliable change of symptomatology. Literature focused on evaluations of the English IAPT initiative was discussed in Chapter 3 therefore, in order to clarify the rationale for the evaluation methods employed. More specifically, within Chapter 3, rates of reliable

improvement, deterioration and recovery were determined in relation to both symptoms of depression and anxiety in order to present outcomes comparable with English IAPT outcomes. Furthermore, the longer term effectiveness of the treatment was examined by determining how rates of reliable change in symptomatology may or may not have been maintained at a four month follow up point after the end of treatment.

In addition to this evaluation, a subsequent arm of the quantitative evaluation presented in Chapter 4 identified which individual level pre-treatment variables potentially increased or decreased the effectiveness of the intervention by employing a growth mixture modelling method. The research discussed in Chapter 4 highlighted the reasons for employing this method, in addition to a discussion of previous literature on predicting treatment outcomes.

The final arm of the evaluation was carried out using qualitative methods and these outcomes were presented in Chapter 5. Specifically this explored the perspectives of service providers in relation to how this new service model may or may not have improved access to psychological therapies in NI. The research literature discussed in this chapter elaborated on the meaning of ‘improving access’ and in particular explored issues around availability, utilization, efficiency and equity.

Finally the project considered how the new service model evaluated in the current thesis, might be delivered to other suitable patient populations in NI, namely those with medically unexplained symptoms (MUS) and associated anxiety. This final research question was addressed by presenting the outcomes of a service needs analysis in Chapter 6 and subsequently in Chapter 7, a systematic review of the evidence for low intensity interventions in relation to MUS. The needs analysis

presented in Chapter 6 specifically reported on the prevalence of non-cardiac chest pain (NCCP) in an ED in NI. In addition to the outcomes of the needs analysis, literature highlighting the links between NCCP and anxiety was discussed in order to clarify the rationale for potentially offering a PWP service to these patients. The effectiveness of psychological interventions for this and similar patient populations was examined through the systematic review presented in Chapter 7, with a view to highlighting the feasibility of using PWPs.

A more detailed overall summary of the thesis findings, their wider impact and implications, recommendations for clinical practice and future research, was discussed in Chapter 8.

List of abbreviations

4DSQ	Four-dimensional symptom questionnaire
ACQ	Agoraphobic cognitions questionnaire
ADIS	Anxiety disorder interview schedule
AMH	Action Mental Health
APA	American Psychological Society
ASI	Anxiety sensitivity index
BABCP	British Association for Behavioural & Cognitive Psychotherapies
BDI	Beck depression inventory
BME	Black and minority ethnic
BPI	Brief pain inventory
BPS	British Psychological Society
BSI	Bradford somatic inventory
BSI-GSI	Global severity index
BSI-SOM	Brief symptom inventory – somatization subscale
BSQ	Bodily sensations questionnaire
CAQ	Cardiac anxiety questionnaire
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CGI-I	Clinical global impression-improvement
CGI-S	Clinical global impression-severity

CIDI	Composite international diagnostic interview
CORE-OM	Clinical Outcomes in Routine Evaluation-Outcome Measure
CPUC	Chest pain of unknown cause
DAS	Dysfunctional attitude scale
DASS	Depression anxiety and stress scale
DHBQ	Dysfunctional health beliefs questionnaire
DHSSPS	Department of Health Social Services and Public Safety
DOH	Department of Health
DSM	Diagnostic and Statistical Manual of Mental Disorders
ED	Emergency Department
ENDPB	Executive Non-Departmental Public Body
EQ-5D	Health related quality of life
FQ	Fear questionnaire
FSQ	Functional status questionnaire
FSS	Fear survey schedule
GAD	Generalised anxiety disorder
GAD-7	Generalised Anxiety Disorder Scale
GHQ-9	General health questionnaire
GP	General Practitioner
HA	Heath Anxiety
HADS	Hospital anxiety and depression scale
HAM-A	Hamilton anxiety scale
HAM-D	Hamilton depression scale
HCQ	Hypochondrial cognitions questionnaire
HRQOL	Health related quality of life

HSC	Heath and Social Care
HSCB	Heath and Social Care Board
IAD	Illness anxiety disorder
IAPT	Improving Access to Psychological Therapies
IAS	Illness attitude scale
ICD	International Classification of Diseases
IES-R	Impact of Events Scale Revised
IPA	Interpretative phenomenological analysis
IRAS	Integrated research application system
JIBT	Jones irrational belief test
KKG-I	‘internal control’ subscale (multidimensional sr questionnaire)
LICBT	Low intensity cognitive therapy
LTC	Long term conditions
MAF	Measure of general functioning
MI	Agoraphobia-Mobility Inventory
MINI	Mini international neuropsychiatric interview
MOS SF-36	Medical outcomes study 36 item short-form health survey
MOS-10	Medical outcomes study (physical subscale)
MUS	Medically Unexplained Symptoms
NAO	National Audit Office
NAS	Negative affectivity scale
NCCMH	National Collaborating Centre for Mental Health
NCCP	Non-cardiac chest pain
NEO-PI	Personality inventory
NHL	Nijmegen hyperventilation list

NHP	Nottingham health profile
NHS	National Health Service
NI	Northern Ireland
NICE	National Institute for Health and Care Excellence
NISRA	Northern Ireland Statistics and Research Agency
OCD	Obsessive compulsive disorder
OCI	Obsessive Compulsive Inventory
ORECNI	Office of research and ethics committee
PACS	Primary and acute care systems
PAS	Panic and agoraphobia scale
PD	Panic disorder
PDS	Pain Discomfort Scale
PDSS	Panic Disorder Severity Scale
PHQ-9	Patient Health Questionnaire
PRIME-MD	Primary care evaluation of mental disorders
PSC-51	Physical symptoms checklist
PTSD	Post-traumatic stress disorder
PWP	Psychological wellbeing practitioner
QOL	Quality of life questionnaire
RCPCH	Royal College of Paediatrics and Child Health
ROMS	routine outcome measures
SCL-90	Symptom checklist
SDIH	Structured diagnostic interview for hypochondriasis
SIP	Sickness impact profile
SIS	Severity of illness scale

SLE	Stressful life events
SOMS-7	‘State’ version of the screening for somatoform symptoms scale
SPI	Social Phobia Inventory
SSD	Somatic symptom disorder
SSI	Somatic symptoms inventory
SSS	Severity of somatic symptom scale
STAI	State trait anxiety inventory
SUI	Summary utility index
UCP	Unexplained chest pain
VAS	Visual analogue scale
WHO	World Health Organisation
WI	Whitely index
WSAS	Work and Social Adjustment Scale

Declaration

I hereby declare that with effect from the date on which the thesis is deposited in Research Student Administration of Ulster University, I permit:

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Orla McDevitt-Petrovic 23.05.19

Chapter 1

Introduction

Chapter 1 Overview

Across the UK as a whole, approximately one in four people will have a mental health difficulty each year (Mc Manus et al., 2009). Without access to timely and suitable care, there are detrimental societal and economic consequences. It has been estimated that mental illness costs the UK economy up to £100 billion annually (National Collaborating Centre for Mental Health 2010) (NCCMH, 2010). The initiative IAPT has transformed the treatment of depression and anxiety for adults in England, with more than 900,000 people accessing these services annually. The current project seeks to evaluate a service modelled on IAPT in England which may provide preliminary evidence that a similar service model could also be effective in NI. This introductory chapter includes detailed background information. More specifically the rationale for the implementation of the IAPT initiative is presented in addition to details of the pilot demonstration sites and the specification for the existing IAPT service model.

The service developments currently underway are also discussed, the aim of which is to increase service access for those with physical health conditions or medically unexplained symptoms (MUS) who have mental health comorbidities. The key issues in relation to mental health in NI are discussed in order to clarify the rationale for evaluating an IAPT type service model in NI, thereby presenting the framework for the current research.

1.1 Common mental health difficulties

The term common mental health difficulties refers primarily to depression and a range of anxiety disorders (National Institute for Health and Care Excellence 2011a) (NICE, 2011a). There has been some dispute regarding diagnostic categories and criteria in relation to these given the considerable overlap in symptoms (Bentall, 2004; Guy, Loewenthal, Thomas & Stephenson, 2012; Mollon, 2009). However given the wide use and acceptability of the term, it is the most appropriate to use in the context of the current thesis.

Depression and anxiety disorders have a significant impact on the individual, on healthcare services and on society as a whole. In relation to personal adverse psychological and social consequences there is increased distress, reduced quality of life, unhealthy lifestyle choices, poorer physical health, poorer educational attainments, poorer quality employment and increased risk of relapse where there is inadequate access to the correct interventions. Approximately 16% of the UK population experiences depression and anxiety each year, consequently contributing more than 50% of the burden created by general mental health problems (Andrews, Issakidis & Carter, 2001). An undetected or untreated mental health problem has been found to be the most common reason for frequent attendance of healthcare services. In England common mental health problems are estimated to reduce national income by up to £80,000,000 as a result of decreased productivity, and increased unemployment and welfare costs (Burton et al., 2012).

1.1.1 Depression

Depression is a complex yet common mental health problem which is characterised by changes in mood, patterns of thinking and behaviour, relationships, and biological functioning including sleep and appetite (Carr & McNulty, 2006). It has been suggested that vulnerability to depression may exist due to genetic factors, experiences of early loss, or both, and that episodes of illness are subsequently triggered by stressful life events or by an accumulation of smaller stressors (Carr & McNulty, 2006). An episode of depression is often maintained by continuing high levels of environmental stress whereby the demands exceed the personal resources to manage. Low mood may be furthermore maintained by low activity levels, reduced positive social interactions, lack of sufficient support networks and having a depressive cognitive style (Carr & McNulty, 2006). Numerous key symptoms and diagnostic features of a depressive episode are highlighted within the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (American Psychological Society, 2013) (APA, 2013), and the International Classification of Diseases (ICD-10) (WHO, 1993), including depressed mood, lack of interest in many daily activities (anhedonia), fatigue, appetite and sleep changes, psychomotor retardation or agitation, low self-esteem, excessive guilt, poor memory and concentration, and thoughts of suicide. The severity of depression (i.e., whether symptoms are mild, moderate or severe), is often determined by the number of symptoms and the degree to which these interfere with an individual's ability to function at previously 'normal' levels.

1.1.2 Anxiety Disorders

Anxiety is quite a normal reaction to threats, and an important motivator. However it is important to understand that experiencing a state of anxiety is not the same as experiencing an anxiety disorder. Although anxiety disorders are common, they are frequently distressing, disabling and chronic (Andrews et al., 2003). In relation to the clinical symptoms of anxiety, it has been described as ‘an unpleasant emotional state experienced as fear or something close to it. It is unconnected with, or disproportionate to, environmental threats, and is associated with bodily discomforts’ (Roth & Argyle, 1988: 33).

Anxiety can be present within a number of commonly diagnosed disorders; the target of the fear which accompanies the anxiety helps to identify the specific disorder. The most common anxiety disorders are described below:

- Generalised anxiety disorder (GAD) is a chronic state of worry which occurs frequently and intensely or in situations where it is unhelpful. Worry in this case is used to control the anxiety.
- Panic disorder with or without agoraphobia (PD). Panic disorder occurs when physical symptoms such as a fast heartbeat or unusual sensations result in a fear or belief that these symptoms are dangerous. The subsequent reactions to this belief (e.g. hyperventilation) often cause symptoms to become worse. Agoraphobia (extreme fear of open/public spaces) may or may not occur with PD.
- Social anxiety disorder is an exaggerated fear of negative evaluation by others, often leading to avoidant behaviours.

- Obsessive compulsive disorder (OCD) is a condition involving intense anxiety often triggered by intrusive thoughts after which a compulsive behaviour is performed in order to neutralize them.
- Phobias are extreme fears relating to situations or objects. They differ from ‘normal’ fears given that the intensity of fear is disproportionate to the reality of the threat. Some of the more commonly seen phobias include blood, dogs, heights, flying and public speaking.

Mixed depressive and anxiety disorder is also a common presentation, and it can be challenging for mental health practitioners to distinguish between them, as during practice they may not always present distinctly (Brown, Campbell, Lehman, Grisham & Mancill, 2001; Blackburn & Davidson, 1995).

1.2 Improving Access to Psychological Therapies (IAPT) : Key Features

IAPT is a large scale initiative into which there has been a substantial government investment in England. It was first implemented there in 2007, and aims to improve access to evidence based psychological treatments for common mental health difficulties, primarily depression and anxiety. (Clark, Layard, Smithies, Richards, Suckling and Wright, 2009). The concept of evidence-based practice requires clinical decisions regarding treatments to be based on determined effectiveness and appropriateness for patients; robust clinical evidence is gathered through theory, observations and experimentation thereby quantifying knowledge in order to make recommendations reflective of current need and context (Spring, 2007; Sackett et al., 1996).

Committing to the application of evidence based practice within the National Health Service (NHS) facilitates equitable access to novel and effective care (NICE, 2011a).

Access as stipulated by the IAPT clinical model, specifically refers to the provision of treatments which embrace utilization, and availability, as well as efficiency and effectiveness. Access also refers to equity and the drive to promote a culture of social inclusion and patient centeredness in order to facilitate improved access for all sectors of society (Gulliford, Hughes and Figeroa-Munoz, 2001). IAPT have published several positive practice guides for commissioners and service providers in order to inform and enhance equity of access and treatment outcomes for particular patient populations including those with long term conditions, those requiring perinatal, postnatal or antenatal care, those with learning disabilities, veterans, those in contact with the criminal justice system, older adults and black and minority ethnic groups. It has been stipulated that equity of service access and treatment outcomes will be achieved when the proportion of individuals accessing services is representative of the local population profile, when there is increased diversity among those seeking help for mental health difficulties, and when recovery rates are not determined to be impacted by gender, age, race, cultural values, religious beliefs, marital status, pregnancy or maternity (NCCMH, 2018). A number of key features of the IAPT initiative are discussed below namely adherence to NICE guidelines and the stepped care model, an increased focus on low intensity interventions, the introduction of a new workforce, routine outcome monitoring and the introduction of a self-referral pathway.

1.2.1 NICE guidelines

A key characteristic of the IAPT programme is adherence to National Institute for Health and Clinical Excellence (NICE) clinical guidelines which convey accurate interpretation of evidence based practice (Kendall, Pilling, Glover & Clare, 2011).

NICE is a UK executive non-departmental public body within the Department of Health which serves the NHS in England and Wales. Originally it was established as the National Institute for Clinical Excellence in 1999, but as a result of amalgamation with the Health Development Agency in April 2005, it was subsequently referred to as the National Institute for Health and Clinical Excellence (still abbreviated as NICE). In order to account for their new authority within social care, NICE changed from a special health authority to an Executive Non-Departmental Public Body (ENDPB) in April 2013, and has since been referred to as the National Institute for Health and Care Excellence) (NICE “who we are”).

NICE publish guidelines in relation to health technologies within the NHS, guidelines pertaining to clinical practice which includes the appropriate treatment and care of people with specific conditions, guidelines for public sector employees regarding health promotion and illness prevention, and guidelines for those using social care services. These appraisals are based primarily on evaluations of efficacy and cost-effectiveness in various circumstances (Drummond, Sculpher, Claxton, Stoddart & Torrance, 2015).

NICE has established a number of National Collaborating Centres linking expertise from the royal medical colleges, professional bodies and patient/carer organisations. Designated Guideline Development Groups within the relevant National Collaborating Centres work on clinical guidelines which pertain to the most appropriate treatment options for various diseases. The group collaboratively assess the evidence based on clinical outcomes and economic validity after which stakeholder feedback is provided across two consultation periods. When recommended amendments have been completed, the Guideline Development Group

finalises the clinical guidelines which are subsequently passed to NICE for formal approval (NICE “who we are”).

NICE guidelines advocate the use of cognitive behavioural therapy (CBT) for depression and anxiety, and adherence to these professionally developed guidelines enhances scientific credibility for psychological therapies (Kendrick & Peveler, 2010).

In 2004, NICE carried out systematic reviews of research investigating the effectiveness of interventions for depression and anxiety disorders. The resultant clinical guidelines advocate the provision of specific kinds of CBT for depression and anxiety disorders (NICE, 2004a, 2004b, 2005a, 2005b, 2006, 2009a, 2009b, 2011, 2013). Several other therapies such as counselling and brief dynamic therapy are also advocated for depression but not for anxiety. CBT is considered to be more effective than medication given that it reduces the likelihood of relapse by at least 50%, and moreover, the vast majority of patients prefer it to a psychological treatment (McHugh, Whitton, Peckham, Welge and Otto, 2013).

1.2.2 Stepped Care

Importantly NICE guidelines furthermore advocate that interventions are delivered and monitored according to a stepped care approach. This requires that the most effective yet least resource intensive intervention which is relevant to a client's difficulties is offered first (Firth, Barkham & Kellett, 2015).

Furthermore, stepped care requires that treatment should be modified in accordance with client need after considering the client's treatment response, and the practitioner's clinical judgement ('Self-Correcting' Mechanism) (Bower & Gilbody, 2005). Importantly then, NICE guidelines indicate that mild to moderate level mental

health difficulties can be effectively managed with low intensity CBT (LICBT). In relation to common mental health difficulties, ‘mild’ and ‘moderate’ are clinical terms which indicate the severity of symptomatology including onset, chronicity, and frequency (Department of Health, 2011) (DH, 2011).

By employing this model of stepped care and adhering to NICE guidelines, IAPT services can offer low intensity interventions while reserving higher intensity and more specialist treatments for those who have more severe symptoms, or for those who have not achieved improvement after a low intensity treatment and need to be ‘stepped up’

1.2.3 CBT and LICBT

Essentially the aim of CBT is to challenge and ultimately change the behavioural and cognitive factors assumed to be responsible for maintaining psychological distress (Beck & Carlson, 2006). CBT is currently the most widely utilised therapeutic model within the scope of evidence based psychological therapies. As a consequence of the wealth of empirical support for CBT, it is frequently the first non-pharmacological intervention of choice for many high prevalence mental health difficulties including depression and anxiety disorders (Bennet-Levy, Richards & Farrand, 2010).

Although the evidence supporting the effectiveness of CBT in primary care is robust (Twomey, O’Reilly & Byrne, 2015), there are less research outcomes supporting its use among specific minority groups including ethnic minorities and those with low socio-economic status (Hoffman et al., 2013).

LICBT in this case represents forms of CBT treatment which require less practitioner support in terms of the frequency and duration of sessions, and as a consequence it

has previously been referred to as ‘High Volume Low Intensity’ CBT (Richards & Suckling, 2009).

The primary aim of low intensity CBT (LICBT) interventions is to increase access to evidence based psychological therapies in order to improve mental health and wellbeing throughout all community sectors, and to implement the minimum level of intervention required in order to achieve the maximum gain i.e. as per the stepped care approach (Bower and Gilbody, 2005). An important function of LICBT is one which facilitates early access to services.

This is crucial given that a relatively small amount of therapeutic intervention early in the development of difficulties can significantly alter the trajectory of mental ill health; problems may become enduring, chronic and more severe as time without intervention passes. (Papworth, Marrinan, Martin, Keegan & Chaddock, 2013).

As indicated previously, when compared with high intensity CBT interventions, low intensity treatments reduce the amount of time practitioners are in contact with patients. Time reduction is most often achieved by supporting clients through their use of self- help materials (self-help books, computerised CBT), reducing the duration and frequency of sessions, and by facilitating clients’ engagements with third party organisations.

The content of CBT resources is also frequently less intense with the aim of communicating CBT principles in more flexible formats. Clients can choose to have face to face, email or phone contacts and the resources used are self-paced and divided into small manageable sections. (Bennet-Levy et al., 2010).

In general, LICBT interventions are relatively simplistic and brief with a principal focus on self-help materials and techniques. The value of completing work at home

in between sessions is highlighted. Therefore, LICBT is essentially a form of guided self-help. Guided self-help itself may be defined as a psychological treatment requiring patients to take home standardised treatment resources, and to work through them on a largely independent basis (Cuijpers and Schuurmans, 2007). In this case it is particularly important to be clear about the differences between guided self-help and pure self-help, with the former being distinguished due to the provision of support from the practitioner.

It has been suggested that the emergence and delivery of low intensity interventions or guided self-help represents ‘a revolution in mental healthcare’ (Bennet-Levy 2010, p.3). Much evidence exists supporting the clinical effectiveness of LICBT (Bower et al., 2013; McHugh, Gordon & Byrne, 2014; Papworth et al., 2013).

More specifically, several randomised controlled trials and meta-analyses have demonstrated the efficacy of guided self-help in reducing depressive and anxiety symptomatology. Gellatly et al. (2007), reviewed 34 studies focusing on self-help and depression, and found that guided self-help was clinically effective, and furthermore, that it was more effective when CBT based materials were used.

Lewis et al (2003), considered the effects of self-help on several mental health disorders, and found significant improvements in cases of depression, general anxiety and panic disorder. Similarly, in a meta-analysis, Coull and Morris (2011), found guided self-help to be effective for anxiety disorders. Lewis, Pearce and Bisson (2012) included 31 randomised controlled trials evaluating the effectiveness of guided self-help on anxiety disorders in a meta-analysis and found significant evidence of efficacy in cases of generalised anxiety, panic disorder and social phobia. Although additional research is required, overall the aforementioned studies

provide evidence for the clinical effectiveness of self-help as an intervention for depression and several anxiety disorders. Moreover, consistent with a LICBT approach, the research concludes that CBT based resources are particularly effective, as is the provision of guided support from a practitioner. Importantly, more significantly positive effects were observed for participants recruited via the media reflecting the service promotion and self-referral options facilitated by a LICBT service model (Lewis et al., 2012).

It has been stipulated that when compared with traditional mental health services, LICBT interventions do increase the access and speed of access to treatment, and furthermore, that they increase the total number of individuals who can access evidence based psychological treatments. Additionally, they have been found to improve the flexibility, capacity and responsiveness of the relevant services while increasing patient-choice, and enhancing service cost-effectiveness. (Bennett-Levy et al., 2010). Importantly it has been posited that low intensity interventions possibly reduce the risk of relapse given their focus on self-management (Bennett-Levy et al., 2010; IAPT, 2011).

1.2.4 A new workforce

Therapies within IAPT services are delivered by fully trained and accredited practitioners, and interventions are based on the intensity and duration of each client's difficulties in order to optimize treatment outcomes as per NICE guidelines and a stepped care framework. LICBT for mild to moderate level depression and anxiety disorders is delivered by psychological wellbeing practitioners (PWP's); further details about the PWP role are provided in Chapter 2. Qualified high intensity therapists within IAPT deliver evidence-based therapies for a range of moderate to

severe mental health problems. They offer different types of therapy relevant to the client's difficulties including high intensity CBT, counselling, interpersonal therapy, brief psychodynamic therapy and couples therapy.

Regular and good quality clinical case management and clinical skills supervision are key processes which are fundamental to the success of the IAPT programme. Training for IAPT supervisors is based on a competency framework developed specifically for the programme (IAPT 2008a; Richards & Whyte, 2011). Further details on supervision are outlined in Chapter 2.

1.2.5 Routine Outcome Monitoring

Another key feature of IAPT services is the collection of routine outcome measures (ROMS) at every session. In the past, data collection within mental health services has typically been inadequate, with data completion rarely exceeding 33-38% even where standardised measures are employed (Stiles et al., 2006, 2008). Poor data completion makes service refinement and implementation more difficult (Appleby, Baird, Thompson & Jabbal, 2015).

Before the establishment of the IAPT programme, the majority of psychological services were evaluated through the collection of measure scores at the beginning and end points of treatment only. Given that patients do not always complete a course of treatment when expected, and that practitioners did not routinely administer psychometrics, post-treatment data were frequently missing for a large proportion of patients. Moreover, research determined that this increased the likelihood of services overestimating their effectiveness due to the fact that patients who discontinue treatment often have poorer outcomes (Clark et al., 2009).

All IAPT services routinely collect data on local IT systems which are subsequently collated monthly by NHS Digital for analysis and national reporting. If the presenting problem is depression, general anxiety disorder or mixed depression/anxiety, the Patient Health Questionnaire (PHQ-9) and Generalised Anxiety Scale (GAD-7) are to be administered at every session. A number of additional measures have been recommended for use in other specific disorders, namely the Social Phobia Inventory (SPIN) for social anxiety, the Obsessive Compulsive Inventory (OCI) for OCD, the Impact of Events Scale Revised (IES-R) for PTSD, the Agoraphobia-Mobility Inventory (MI) for agoraphobia and the Panic Disorder Severity Scale (PDSS) for panic disorder. The PHQ-15 is also recommended for medically unexplained symptoms (MUS). The use of additional measures is important as it can in some cases prevent patients being discharged too early (if clinicians relied solely on the PHQ-9 and GAD-7).

It has been established that the session by session monitoring procedures followed by IAPT has resulted in their services obtaining outcome data on 98.5% of patients who undergo a course of treatment (NCCMH, 2018).

In addition to increasing the amount of post treatment outcome data obtained, data also ensure equitable use of IAPT services. More specifically the demographic information collected on service users can be used to identify and subsequently address any barriers to the provision of and access to services. Much evidence exists to support the use of routine outcome measures (ROMS) within routine clinical practice, and more specifically this illustrates how they can help to identify those who are struggling to achieve treatment gains or are deteriorating (Boswell et al., 2015; Delgadillo et al., 2014; Knaup, Koeslars, Schefer, Becker & Puscher, 2009; Lambert, 2010; Shimokawa, Lambert & Smart, 2010).

Monitoring how scores might fluctuate and change provides important information to the practitioner, and can help them to determine appropriate treatment goals on a sessional basis. Furthermore, it gives practitioners an insight into whether particular interventions are working and whether a change or step up is required. This information is also important for the therapist within supervision, which should be outcomes focused. The therapist and supervisor review scores and individual item scores in order to assess patient progress, areas to focus on, and in order to inform decisions around stepping up. Importantly it is also extremely beneficial for clients to see changes in their scores throughout treatment; this increases the patient's understanding of their own difficulties and can further encourage and motivate them to achieve treatment goals, in addition to strengthening the therapeutic alliance (NCCMH, 2018).

IAPT services as a whole, can furthermore use outcome data to ensure interventions are being provided in accordance with NICE guidelines, that treatments are of an adequate duration, and that waiting times from the point of referral are not excessive.

Those managing an IAPT service can also evaluate the performance of their own service and identify issues to address relating to service quality, cost effectiveness and clinical outcomes. This information on a regional and national level is also important for policy making.

1.2.6 Expanding referral pathways

Historically within the NHS, the majority of patients avail of psychological therapies following a general practitioner (GP) referral. However, it was considered that this may be a potential barrier to access for some individuals typically underrepresented in GP referrals, such as those from black and minority ethnic communities.

Consequently, the IAPT service model facilitated the provision of care for self-referrals in order to determine if this identified individuals with mental health difficulties who would not have accessed services in other circumstances (Clark et al., 2009).

1.2.7 Rationale for the implementation of the IAPT initiative

The motivating factors for the implementation of the IAPT initiative centred around both clinical and economic recommendations. A national survey of 16-64 year olds in Britain over a seven year period (1993-2000) reported that only 25% of individuals with a mental health problem were receiving a form of treatment in 2007, which was unchanged from 2000 (Jenkins et al., 2009). Furthermore, the survey revealed that medication use for mental health difficulties had doubled between 1993 and 2003. During the same period, the overall prevalence of mental disorders did not change significantly, and the use of evidence based psychological therapies did not significantly increase. (Brugha et al., 2004).

Findings from the 2007 English Adult Psychiatric Morbidity Survey indicated that older respondents were 80% less likely than younger respondents to receive talking therapy and were 50% less likely to have contacted their GP in the previous year regarding mental health. Ethnic minorities were less likely to be receiving antidepressant medications and were less likely to have consulted their GP in the previous year regarding mental health. (Cooper et al., 2010). Research has suggested that patient choice enhances treatment effectiveness (Geers, Rose, Fowler, Rasinski, Brown, and Helfer, 2013), and moreover that approximately twice as many patients prefer a psychological intervention to a pharmacological intervention (Kwan, Dimidjiamn & Rizvi, 2010).

However, a very small proportion of individuals with common mental health difficulties are actually offered an evidence based psychological intervention (McManus, Melltzer, Brugha, Bebbington & Jenkins, 2009).

A number of potential economic and social benefits have been outlined by economists and clinical researchers. More specifically they suggested IAPT would predominantly pay for itself, given that improved access to evidence based psychological treatments for common mental health difficulties would significantly reduce the suffering and public costs associated with depression and anxiety. (Layard et al 2006, 2007). Throughout most countries worldwide, the majority of mental healthcare budgets are dedicated to the provision of care for those with severe and complex difficulties such as psychosis (WHO, 2001). However, such difficulties are relatively rare when compared to the prevalence of anxiety disorders and depression. The IAPT initiative facilitates a public health approach to treatment of mild to severe depression and anxiety disorders (Layard, 2006; Richards and Suckling, 2009).

The financial burden of depression in the UK was estimated at approximately 105 billion pounds in 2009/2010, of which 30 billion was considered to be associated with work (Sainsbury Centre, 2010). Moreover, the estimated spend for benefits to those unemployed who have depression, or an anxiety disorder is 7-10 billion (Centre for Economic performance 2006).

1.3 Pilot demonstration sites: Doncaster and Newham

The UK government made the initial general commitment to increase access to evidence based psychological treatments in 2005. However, prior to finalising decisions regarding the scale and precise direction of this, two pilot projects were funded with a view to evaluating the effectiveness of the programme, and to determine if outcomes would reflect expectations. Specifically, the outcomes of these pilots were used to suggest that increased government funding would enable the improvement of clinical results both in terms of the degree of improvement and the actual volume of treatment, which would consequently validate the level of investment (Richards and Suckling, 2009). Progress monitoring is critical for adjusting and advancing treatments, helps patients to select a service which has good outcomes, and allows those who fund the service to clarify if their investment is cost beneficial. (Layard and Clark 2014; Radhakrishnan, Hammond, Jones, Watson, McMillan-Shields and Lafortune, 2013). Both the Doncaster and Newham primary care Trusts in England received funds facilitating the recruitment and use of a workforce wholly comprised of CBT-focused psychological therapists (Richards and Suckling, 2009). The demonstration sites were chosen on the basis that they each served vastly contrasting catchment areas (Clark et al., 2009).

More specifically, this resulted in the establishment of a different type of service model in each; the Doncaster site focused on low intensity, high volume provision and the Newham site which emphasised the opposite. In order to address increasing demand, both sites ultimately adopted the low intensity focused model (Clark et al., 2009; Kuhn, 2011; Richards & Suckling, 2009).

The number of individuals accessing services at the pilot sites was more than expected ($n=3,471$), and waiting times (3-4 weeks), and recovery rates (55-56%) were also better than expected, as were the rates of data completion (Clark et al., 2009).

A session by session outcome monitoring system was employed by each site, given that this method had achieved high levels of pre and post data completeness in community samples (Gillespie, Duffy, Hackman and Clark, 2002). Clients completed routine outcome measures at each contact, namely the nine item PHQ-9 and the seven item GAD-7 which gauge the severity of depressive and anxiety symptoms respectively. Further details of these specific measures are outlined in the Chapter 2.

High levels of data completeness were facilitated by the session by session monitoring protocol. Both self and GP referrals had similar baseline measure scores, although self-referrals were inclined to have had difficulties for longer. Crucially self-referral allowed for more accurate tracking of ethnic minorities who tend to be underrepresented among GP referrals. Higher levels of conditions which are typically under recognised, namely social phobia and post-traumatic stress disorder (PTSD) were detected among ethnic minorities. The government included self-referral in the subsequent national roll-out of IAPT as a consequence of this finding.

All patients who completed at least two sessions were included in the evaluation, irrespective of their reasons for discontinuing treatment i.e. completed or dropped out. Patients attending both sites achieved significant improvements.

Patients were regarded as clinically recovered if they scored above the clinical cut off on the PHQ-9 and/or GAD-7 at pre-treatment and below the cut-off point on both measures at post treatment. Details of reliable improvement and reliable recovery criteria in IAPT are provided in the Methodology (Chapter 2).

Based on this criteria, recovery rates for Doncaster and Newham were 55% and 56% respectively. Those who had self-referred and members of ethnic minority communities were no less likely to recover than GP referrals and Caucasians.

The potential economic benefits of IAPT were argued based on the assumption that clinical improvements would be sustained thereby facilitating an improvement of patient's employment status as well as clinical symptoms. (Layard, Clark, Knapp and Mayraz 2007). In order to consider if clinical improvements were sustained, patients were asked to complete the measures again at an average of nine months following treatment completion. Although data completeness at this point was relatively low compared with post treatment data (36% and 51% in Newham and Doncaster respectively), the improvements achieved during the course of treatment were predominantly maintained. Pre and post-employment statuses were compared, with findings indicating a 5% overall improvement rate in employment status, compared with the predicted 4% (Layard et al., 2007).

Clark et al. (2009) suggested, that although these findings were in line with predications, some of the improvements in the cases of more recent onset depression (within the last six months) were possibly due to natural recovery. However, recovery rates among recent onset and chronic cases were compared, and indicated that the rates for those depressed for more than six months (52% at each site), adequately eclipsed the 5-20% that would be expected from natural recovery or minimal intervention (Clark et al., 2009).

1.4 Specification of the national IAPT model

Following the success of the pilot sites, 11 pathfinder sites were commissioned in order to establish specialist services for specific sub groups based on catchment areas. Recovery rates from these sites were considered to be acceptable (IAPT 2008b) although there were significant variations in service provision. The Department of Health then released a 'National Implementation Plan' in 2008 facilitating the establishment of IAPT services in all areas of England across a six year period. The IAPT Implementation Plan (DH, 2008) outlines a generic framework applicable to all services, yet this permits substantial scope for implementation at a local level. Guided by this systematic framework, IAPT has successfully trained a skilled workforce who deliver evidence based interventions with the principal objective being a significant reduction in waiting times and improved access to care (Clark, 2011; IAPT 2011).

The nationwide implementation of the IAPT initiative was divided into three waves occurring across three years, which enabled services to establish gradually and allowed the clinical model to be refined and modified as necessary.

The success of the pilot sites at Newham and Doncaster and the significance of the findings which emerged from these evaluations, subsequently informed the national roll-out of IAPT services. Funding totalling £309 million was provided throughout the three years of implementing services, during which 3600 new psychological therapists were trained (60% as CBT therapists and 40% as PWPs). They were employed to work according to a stepped care approach treating depression and anxiety disorders. The primary focus initially was on CBT given the NICE recommendations and extensive evidence base, in addition to the fact that there was a lack of trained CBT practitioners at this time. Initial targets specified that 50% of service users would move to recovery and that the number of individuals on sick pay or on receipt of state benefits would decrease by 25,000 nationally. It was expected that 20 out of 154 Primary care trusts in England would have established services in this first year (2008-2009) with others implementing the programme in the future (DH, 2008). Separate curricula are used in training the high intensity and low intensity practitioners and are delivered as a combination of both in university and onsite training.

Primary Care Trusts were replaced by Clinical Commissioning Groups (CCGs) in England, in April 2013. They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. Clinical Commissioning Groups (CCGs) commission the majority of the hospital and community NHS services in their respective local areas.

Commissioning essentially involves deciding what services are required for particular sub populations, and subsequently ensuring these are delivered. CCGs remain part of NHS England, which continues to hold responsibility for commissioning primary care services including GP practices, in addition to certain specialised hospital services. All GP practices are now attached to a CCG, although the CCGs also include other health professionals, such as nurses. Services CCGs commission include the majority of scheduled hospital care, rehabilitative care, urgent and emergency care (including out-of-hours), the majority of community health and wellbeing services, learning disability services and mental health services.

As of 2015, all 211 CCGs in England have established IAPT services. The National Implementation plan (DH, 2008), stipulated a number of key principles to which all IAPT services adhere to. Firstly, it is essential that services can be accessed via self-referral as well as through a general practitioner. The first session should consist of a person centred assessment interview during which the key problem necessitating treatment is identified, and their social and personal context. Treatment goals and plans are then agreed. Adherence to the stepped care model is key. Service users with mild to moderate depression and anxiety are initially offered a PWP, and step up to a higher intensity service is only offered where it is clinically required i.e. when there has not been recovery following a low intensity intervention. Those with PTSD or severe depression or anxiety are offered a higher intensity service. Liaison with employment advisors is encouraged from early in treatment when required, as this can aid psychological recovery both directly and conversely. As indicated earlier, therapists are also required to receive weekly clinical supervision and to adhere to the session by session monitoring system in relation to routine outcome measures.

Evaluations of IAPT services following the pilot sites provide further evidence for the clinical effectiveness of the model, more specific details of which are provided in Chapter 3.

IAPT is now assessing and treating approximately 13% and 18% of the diagnosable population respectively, amounting to almost half a million people. However, adequate nationwide access has not yet been realised and current waiting times remain lengthy. It has been suggested therefore that the programme must double by 2020 (Layard and Clark, 2015).

Layard and Clark (2015), have reported on cost benefit potentials and reasons why more psychological therapy would cost nothing. In the majority of wealthy countries, approximately 1% of the working age population are on benefits due to depression or anxiety. This costs the UK government £650 more per month per person, compared with if they were not receiving these payments. If 4% of this patient population worked for just one more month following treatment, the actual cost of treatment would be fully repaid. Much larger estimates than 4% have been determined in randomised controlled trials in the UK and in the US (Layard and Clark, 2014).

Additionally, Layard and Clark (2015), have highlighted the potential for savings within physical healthcare. More than 50% of individuals with mental ill health also have a physical health problem. In the UK, the cost of physical healthcare is around £200 more when the individual also has mental health difficulties. Accordingly, if an individual with a physical health problem also received treatment for their mental ill health, annual savings of up to £1000 per year may be estimated as per the 50% recovery rates.

Layard and Clark (2014, 2015) emphasize the fact that such savings are accrued to the authorities subsequently financing psychological therapies namely the NHS in England. The argument to expand service provision is therefore in their view, thoroughly justified.

1.5 Integrating services for mental and physical health

A six point mental health strategy was published by the government in 2011 which encompassed aims to improve treatment outcomes in physical health, the experience of care for those with mental health problems, harm reduction and stigma reduction. Since this time, there has been a reduction in stigmatisation given that public attitudes towards mental health have improved, and there is increased understanding of the urgent need to improve the experiences of those with mental health difficulties (DH, 2011). However, challenges with nationwide implementation of services, and an increase in help seeking has resulted in somewhat inadequate provision, declining treatment outcomes and increased completed suicides (NCCMH, 2018).

Furthermore, there is a long-established tendency within health services to consider physical and mental health as two separate things. The lack of integration between services means that the mental health needs of those with physical health problems are frequently neglected and vice versa. Mental health has not been afforded the same priorities as physical health, and moreover, has been subjected to chronic under-investment. Approximately 40% of individuals with depression and or anxiety also have a long term physical health condition (LTC). Approximately 30% of individual's with a long term physical health condition and 70% of people with MUS also have mental health co morbidities.

For those with LTCs who also have untreated mental health comorbidities, there is a reduced probability of engaging with interventions for their physical health and subsequently a reduction in abilities to self-manage conditions adequately.

Furthermore, an increased chance of engaging in poor health behaviours can lead to worsened physical health and increase the probability of premature mortality. There is also an increased chance of unemployment and absenteeism. (NCCMH, 2018)

The priorities for IAPT service development are thus as follows :

- The expansion of IAPT services in order that at least 1.5 million adults access care each year by 2020/2021, which essentially means that nationwide, 25% of individuals with depression and anxiety access IAPT, compared with the current 15%.
- To continue supporting people to stay in employment or to find employment.
- To improve quality of care and people's experiences of services. More specifically this means increasing the number of clients achieving recovery criteria, reducing geographic variations, and reducing inequalities in both access and treatment outcomes for certain sub-populations
- Increased focus on individuals with long term physical conditions. Two thirds of people with a common mental health difficulty also have a long term physical health problem which increases the cost of their care by up to 45% when compared to those without a mental health problem. These individuals would be better supported if IAPT services integrate with physical healthcare pathways.

The development of existing IAPT services in order to provide for those with LTCs and MUS is underway as of March 2018. The principal goal of this service development is to ensure that those with LTCs and MUS have the same access to NICE recommended evidence based psychological interventions as others, and to facilitate collaboration between physical and mental healthcare practitioners in order to achieve optimum outcomes for clients, regardless of diagnosis.

The aim is to develop these services alongside existing services with clear guidelines for collaborative working. This involves liaison mental health services (also referred to as integrated psychological medicine) which offer care in general emergency departments, as well as inpatient and outpatient clinics. The IAPT-LTC workforce can also include clinical and health psychology services which work within healthcare teams in hospitals, and integrated primary and acute care systems (PACS) vanguards, who work to improve physical, mental and social wellbeing within general practice. Specialist physical health services such as pain clinics based in either community or outpatient settings may also be involved.

Such integration of care, can help to ensure that all health needs are met at the same time; the provision of more comprehensive, accessible and holistic interventions can increase treatment uptake rates, improve overall attendance rates consequently reducing costs. Moreover, integration of care pathways can result in faster diagnosis and reduce rates of repeated attendance. Cost-benefit analysis also suggests that such integration of care can reduce annual expenditure by £1760 per person. (NCCMH, 2018).

The new IAPT-LTC-MUS services are being developed based on the same principles which underpin the existing IAPT initiative, namely that ease of access including self-referral options are facilitated, correct adherence to the stepped care model is maintained, interventions are delivered by fully trained and supervised practitioners, and that collection of sessional routine outcome measures and close links with higher intensity services and employment support organisations continues. Additional key principles within the new integrated services include revised IAPT assessment procedures, accounting for the fact that higher intensity intervention and more complex baseline assessments are probable.

NHS England facilitated 22 ‘early implementer’ IAPT-LTC sites in 2016/17. A further 15 of these sites were operational in 2017/18 and also included provisions for those with MUS. As of April 2018, all clinical commissioning groups are required to provide IAPT services which are integrated with physical care pathways. NHS England have outlined in their strategy; ‘Achieving Better Access to Mental Health Services by 2020’ that the investments of £80 million aim to deliver treatment within 6 weeks for individuals referred to IAPT services, with 95% of these treated within 18 weeks (DH, 2014).

Throughout 2018/19, all CCGs will be asked to recruit more staff in order to implement IAPT-LTC-MUS services. The goal by 2020/21, is that 1.5 million (25%) of adults with depression and/or anxiety will commence treatment, with two thirds of this expansion comprised of LTC and MUS. The overall capacity of IAPT services should be increased through training of both new staff and additional training for existing staff. An expert advisory group made a number of recommendations pertaining to the treatment of depression and anxiety in the context of LTCs and MUS.

They concluded that psychological therapies are effective in people with and without LTCs and furthermore are effective when offered as the sole treatment or when combined with pharmacological interventions. It was also concluded that the best treatment outcomes are obtained when psychological therapies are delivered to gauge the impact of mental health on day to day functioning. It was therefore recommended that psychological therapies within IPAT-LTC-MUS services should be delivered as in existing services while considering the impact of LTCs on mental health problems. Practitioners should promote the self-management of LTCs and consider problematic behaviours and beliefs which may intensify the impact of LTCs on the individuals and their families, or on the degree of engagement with treatment. Interventions should also be modified in consideration of the LTC.

1.6 Mental Health in Northern Ireland

The Northern Ireland (NI) Health Survey (2014/15) reported that 19% of respondents exhibited symptoms of a potential mental health problem (Bell and Scarlett, 2015). The overall prevalence of mental health difficulties in NI is 25% higher than in England. (DHSSPS, 2014). Despite the fact that NI is estimated to have the greatest average health need per person in the UK (NAO, 2012), the proportion of public spending invested in healthcare services has consistently been the lowest. More specifically there has been between 7% and 16% less investment into health and social care in NI compared with England, and England invest more than double the per capita spend than NI into the provision of support for individuals with mental health difficulties and learning disabilities. (DHSSPS, 2010).

Reports reveal there were 268 deaths by suicide in 2014 in NI. (NISRA, 2015). This translates to a rate of 16.4 per 100,000 of the population, the highest among the

regions of the UK (Office for National Statistics, 2016). Suicide rates in NI are highest among young adults, males, and the 'single' marital status group. Furthermore, rates are higher in urban and more socially deprived areas. (DHSSPS, 2012).

NI also has the highest prevalence and annual presentation for self-harm among all UK regions (Carr et al., 2016). Research to date suggests that the high prevalence of mental health difficulties in Northern Ireland is associated with the societal conflict experienced in the region (Bunting, Murphy, O'Neill & Ferry, 2012), and that suicidal behaviours in Northern Ireland are associated with conflict related trauma. (O'Neill et al., 2014). Although the conflict has largely ceased as of 1999, rates of mental health problems associated with trauma remain significantly high. (Ferry, Bunting, O'Neill, Murphy, Stein & Koenen, 2014). Moreover, conflict related trauma, has resulted in a transgenerational cycle whereby the consequences have negatively impacted the mental health of later generations. However, further research on the long-term effects of this is required. (DHSSPS, 2016).

Overall prescription trends indicate that Northern Ireland has significantly higher rates of depression than the rest of the UK; there was a 20% increase in prescription rates for mood and anxiety disorders between 2008 and 2013 (Bell & Scarlett, 2015). Furthermore, prescription costs for anti-depressant medications has been significantly higher in NI compared with other UK regions between 2010 and 2013; 2013 figures also indicate that prescription rates were 66% higher among women than men, and twice as high in the most economically deprived areas. (Bell & Scarlett, 2015).

1.6.1 Socio-demographic correlates of psychological distress

Research has determined that 22% of individuals in Northern Ireland live in poverty. (Bell and Scarlett, 2015). Compared with other regions of the UK, Northern Ireland has the highest proportion of adults not in work (28.4%). More precisely, this is 5% higher than the UK average. (O'Neill, McGregor & Merkur, 2012).

When considering specific groups, the employment rate for disabled individuals is 15% lower than in other UK regions, and is 12% lower for single parents and 16-34 year olds. (Tinson and Macinnes, 2016). Absenteeism is heavily attributed to mental health difficulties, more specifically accounting for 31.9% of all lost days, and 39.1% of long-term sick leave. (NISRA, 2016).

There are higher rates of unemployment among black and ethnic minority communities in Northern Ireland. Figures from the 2011 census indicate an unemployment rate of 12.4% for individuals from Black groups compared with 5% for other residents of working age (Catney and Sabater, 2015; Lucas and Jarman, 2016). Migrants are at increased risk of mental health problems due to lower employment, language and literacy difficulties, social isolation, and transitional challenges. However there is a relatively low uptake of mental health services in NI by black and minority ethnic (BME) communities which has been attributed to several barriers including language, stigma, structural difficulties and cultural values and beliefs.

1.6.2 Mental Health Services: relevant policies and strategies

Service reform within mental health in Northern Ireland has been informed throughout the past decade by the Bamford review; several overarching policy documents outline mental health and associated services in Northern Ireland. The

relevant strategies are described below in order to clarify how services are structured in NI.

The Bamford Review of Mental Health and Learning Disability: The Department of Health, Social Services and Public Safety recommended a review of the law, policies and provisions for individuals with mental health difficulties or learning disabilities in 2001. This is referred to as the Bamford review. The primary objective of the review was to ensure their key recommendations would inform the development of mental healthcare throughout the next 15 years.

The key recommendations included: continued focus on the promotion of positive mental health, the reform of mental health legislation (achieved as per the Mental Capacity Act for NI in 2016), ongoing move from hospital to community-based services, establishment of specialist services for young people, older adults, those with addiction difficulties and those involved with the criminal justice system, an appropriately trained and skilled workforce to deliver these services. The Bamford Review suggested a ten to fifteen year timeframe throughout which these recommendations could be reasonably implemented.

Bamford Action Plans (Implementation and Evaluations): Two action plans were published in 2012 and 2015 based on the recommendations described above (DHSSPS, 2012, 2015). In 2016, the Department of Health Northern Ireland initiated an evaluation of the most recent action plan. Findings highlighted that there remains a need to further promote psychological therapies, to improve access to services in times of crisis, and to improve involvement at the community and voluntary level. Funding reductions are considered to account in part for the failure to fully

implement Bamford recommendations and best practice initiatives throughout the province.

A Strategy for the Development of Psychological Therapy Services (DHSSPS, 2010): This recommends that psychological therapies should be a “core component” within mental health services. Recommendations made in regards to strategy implementation indicate that additional investment, more specifically amounting to 4.4 million, would be required recurrently from 2011 within psychological therapies in order to facilitate opportunities for significant reform.

However, the Bamford Vision acknowledge that further funding would be required across mental health and learning disability services across a 10-15 year period to due to historically inadequate investments and the growing need within Northern Ireland. Recently reported figures indicate that none of Northern Ireland’s five Health Trusts have met the thirteen week waiting time targets for treating individuals with mental illness during the last three years, and local government have already acknowledged the need for a workforce strategy in order to address this (HSCB, 2015). Regarding the perspectives of service users and providers, a recent report from Action Mental Health, reported that service users feel they are not treated like people but as problems to be managed. From a systemic perspective, serious concerns were highlighted regarding inadequate funding, fragmentation of services, poor communication and lack of leadership (AMH, 2015).

Transforming Your Care (DH, 2011): This review proposed a novel integrated model of health and social care specifically in relation to population based planning of services, and a shift from hospitals to community services as per Bamford recommendations. In relation to mental health a number of key issues were

highlighted namely the need for further promotion of mental health and wellbeing, the need to reduce suicide rates among young men in particular, the need to provide clearer information to patients about mental health services, and the need to further promote personalised care.

Making Life Better 2012-2023 (DHSSPS 2014): This is a ten year public health strategy within which the primary goal is improved mental health and wellbeing and reduced rates of self-harm and suicide.

Health and Wellbeing 2026 (DH, 2016) The proposals within this report were formulated as result of the recommendations made by an expert clinically led panel who considered the optimum configuration of health services for NI. The proposals outlined an intention to achieve parity of esteem between mental and physical health in addition to an expansion of services on the community.

1.6.3 Investment in public/health care

Despite the fact that NI is estimated to have the greatest average health need per person in the UK (NAO, 2012), the proportion of public spending invested in healthcare services has consistently been the lowest. More specifically there has been between 7% and 16% less investment into health and social care in NI compared with England, and England invest more than double the per capita spend than NI into the provision of support for individuals with mental health difficulties and learning disabilities. (DHSSPS, 2010).

It is estimated that recent public cuts have affected NI in a particularly detrimental way, given that the region relies on public spending for 62.2% of its output, compared to 39.8% in the rest of the UK. Socio-economic deprivation has been linked with chronic physical health conditions, earlier death and mental health

problems. Indeed in NI, the prevalence of mental health difficulties is doubled for those in the most deprived areas, when compared with those in areas of less deprivation (Bell and Scarlett, 2015).

In 2011, only 7% of the total health budget was spent on mental health (Appleby, Raleigh, Frosini, Bevan, Gao & Lyscom, 2011). 80% of women in NI do not have access to specialist perinatal care compared with 70% and 40% in Scotland and England respectively, and moreover, child health outcomes in NI are among the worst in Western Europe (RCPCH, 2014). The NI ‘Young Life & Times’ survey here revealed that 29% of 16 year old participants has experienced serious personal emotional or mental health difficulties; such experiences were reported by 43% of respondents from more economically deprived backgrounds. (Schubotz and McMullan, 2010). By 2025, 20% of NI’s population will be aged over 65 (Ahern and Hine, 2012). Research to date has suggested that economic deprivation and lower educational levels are associated with poorer mental health in adults over 65, particularly among males (Doebler and Glasgow, 2017).

1.6.4 Health Trusts and care pathways

There are clear differences in how services are set up in NI when compared with other regions in the UK and specifically when compared with the IAPT model in England. As described in Chapter 1, IAPT services operate within a broader system of healthcare and are commissioned by local clinical commissioning groups (CCGs). The service model covers both primary and secondary mental health care usually with a central management and administration hub. This hub has strong links with community sector organisation and primary care services which facilitates easier access for people in local settings such as GP practices or community and

voluntary organisations. Referral pathways are flexible given that they enable people to self-refer or to be referred at the community and primary or secondary care level.

The key is to deliver the correct treatment at the right time in the right place, which requires IAPT services to maintain strong communication with a wide range of healthcare professionals.

The five Health and Social Care (HSC) Trusts in NI were established to provide goods and services for the purposes of health and social care. They are furthermore responsible for exercising specific statutory functions on behalf of the Health and Social Care Board (HSCB), which are delegated to them via authorisations made under the Health and Personal Social Services (Northern Ireland) Order 1994. Each of the Trusts has a statutory obligation to implement and maintain service monitoring and should work to improve the quality of health and social care provision and the environment in which care is delivered (Health and Personal Social Services: Quality, Improvement and Regulation Order 2003) (legislation.gov.uk, 2003)

It is furthermore stated that each Trust must operate with the aim of improving the health and social wellbeing of, and reducing the health inequalities between, those for whom it provides, or may provide, health and social care. Each Trust is responsible for coordinating mental healthcare for individuals in their own geographical locations (Betts & Thompson, 2017; NI Direct, 2018).

In NI the pathways to care for an individuals with common mental health difficulties are not clear. There is no option to self-refer to psychological talking therapies as in IAPT. Rather, an individual must visit their GP who makes the decision to refer to mental health services after which there is no way of estimating waiting times.

Assessments are subsequently carried out by either a psychiatrist, psychologist, social worker or mental health nurse.

Following the assessment the individual is then offered an intervention which will be either talking therapies, family and social care, occupational or lifestyle coaching or drug therapy all of which may be provided by a variety of difference health professionals (Betts & Thompson, 2017; NI Direct, 2018).

In relation to drug therapy and as outlined earlier, it has been recently reported that that GPs in Northern Ireland prescribe anti-depressant medications at a rate 2.5 times higher than in England and Wales. (McClure, 2013). Although the legacy of the ‘Troubles’ may be a contributing factor, prescription rates were found to be significantly higher even in comparison to UK regions with similar economic profiles and even higher rates of depression, which again points to an issue of potentially inadequate access to services. In response, and in order to provide GPs with an alternative to medications for common mental health problems, Primary Care talking therapy hubs were introduced in 2016.

The aim of these hubs is to advocate prevention and early intervention using services including counselling, CBT, group therapy, guided self-help, life coaching and signposting to community services. Although Primary Care Talking Therapy Hubs have been set up in all 5 Heath Trusts in NI, funding varies and the service is not equitable across all Trusts as yet. Moreover, there has been no evaluation of such services to date. There has been recognition from local government that additional hubs with appropriately trained staff are required (HSCB, 2015).

1.6.5 Improving access to psychological therapies in NI

The differences between mental health services in England and NI have now been outlined. Currently, the mental health service framework in Northern Ireland does not formally apply evidence as per NICE clinical guidelines, which inform services within the NHS in England and Wales. Indeed, recent reviews have reiterated that improved access to psychological therapies including CBT is still needed in Northern Ireland, and recommendations have been made to outline a new ten year mental health strategy incorporating a mental health advocate who would consolidate work across local government departments. (Betts & Thompson, 2017). Although the efficacy of early interventions such as low intensity cognitive behavioural therapy (LI-CBT) is most strongly evidenced with depression and anxiety (Gellatly et al., 2007; Ekers et al., 2014), and although such approaches are shown to be cost-effective in the long term (Layard et al., 2007), a stepped care model has not yet been fully established in NI (Blane, Williams, Morrison, Wilson & Mercer, 2014). The challenges for mental health services in NI is further compounded by political instability and the instability of the local devolved government.

Inadequate funding of services (an historic and ongoing issue in NI), due to poor institutional and government support presents challenges in relation to the dissemination and sustainability of treatments (McHugh & Barlow, 2010; Betts & Thompson, 2017; Seward & Clark, 2010).

Psychological therapy service provision in NI has tended to focus on the more complex end of the spectrum of mental health difficulties, and consequently, educational and professional training has similarly concentrated largely on individuals working at these levels; there is commissioned training for staff in

stepped Care level 3 -5 but not steps 1 & 2 (HSC, 2014). In 2013, the Northern Ireland Mental Health Services Threshold Criteria acknowledged that low intensity therapists working at stepped care levels one and two, including those delivering low intensity interventions are crucial for the establishment of an effective stepped care approach to psychological therapy provision in the province (HSC, 2014).

Whilst contemplating how access to care for mild to moderate mental health difficulties may be improved in Northern Ireland, it is useful to consider how such improvements have been achieved in other regions of the UK specifically as per the implementation of the IAPT model and the PWP workforce delivering low intensity interventions.

1.7 Rationale and aims for the current study

The development and nationwide establishment of the IAPT programme in England has been informed by a strong rationale endorsing clinical and economic recommendations. The collection of data and subsequent reporting of treatment outcomes continues to be important in shaping IAPT service modification.

How can we learn from this in NI? In summary, while the IAPT service is well established in England, there is no such IAPT type service model operational in NI. Rather there have been extensive consultations from which needs have been identified. However, service development in NI is slow, underfunded, and lacking adequate evidence to date.

There is a need to evaluate PWPs in a NI context in order to provide preliminary evidence that this could address a need to increase access to psychological therapies through the efficient provision and effective delivery of LICBT. In relation to further service development in NI, and in line with developments in IAPT England, the current project also includes a needs analysis report and a systematic review; specifically these explore how LICBT may be provided for patients with MUS and mental health comorbidities

As indicated within this introductory chapter, research outcomes are an important way in which to secure government support for future service implementation and refinement. The primary objective of the current thesis is therefore to produce research evidence which can inform the future development of effective and accessible mental health services in NI. Specifically the project seeks to provide evidence for the effectiveness of a LICBT service in NI.

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Chapter 2

Methodology

2.1 Changes to MSc Applied Psychology Course at Ulster University

In light of the mental health problems faced by large numbers of the population in Northern Ireland , and in recognition of the need for an appropriately skilled and experienced workforce to fill the gap in service provision highlighted in Chapter 1, the content of the MSc applied psychology course at Ulster University was modified in 2014. This has since facilitated training in evidence-based low intensity interventions for common mental health difficulties. These trainee psychological wellbeing practitioners (PWPs), accredited by the British Psychological Society (BPS), deliver low intensity cognitive behavioural therapy (LICBT) interventions to individuals within Primary/Community Care level services throughout training.

The IAPT training curriculum for PWPs includes compulsory training in the use of CBT- based self-help materials (Richards and Whyte, 2011). Trainee PWPs attend university two days per week, and have one directed learning day on which a guided task is completed independently (e.g. directed reading with written exercise). Two days are also spent seeing clients at the designated placement site. Trainees also attend mandatory individual clinical case management on a weekly basis, and group clinical skills supervision sessions on a fortnightly basis as per IAPT accreditation requirements; all supervisors are BPS or BABCP accredited practitioners and completed the IAPT PWP supervision training course (Richards and Whyte, 2011).

2.2 The role of the LICBT practitioner (Psychological Wellbeing Practitioner).

Within IAPT, low intensity practitioners are referred to as PWPs. The role of a PWP involves several important elements including a structured clinical assessment, the use of the relevant interventions as per step two of the stepped care model, the development of the therapeutic relationship, and the mechanisms aiding recovery. (Richards and Whyte, 2011; Papworth, Marrinan, Martin, Keegan, & Chaddock, 2013).

The role requires a commitment to collaborative care, and a patient centred approach. PWP's are trained to identify and assess common mental health difficulties, and to devise a plan of treatment with the client which is personalised and evidence based (IAPT 2011).

The therapeutic relationship between a PWP and a client may be likened to a CBT self-help 'coach' role whereby the aim is to act as educator and supporter, and to act as a case manager, essentially facilitating communication between the client and any other clinicians or professional who may be involved in their care.

PWP's are required to help motivate the patient to work through evidence based low intensity CBT interventions while acknowledging that the actual work is being carried out by the client who is always considered to be the 'expert' throughout their own recovery journey. The specific content of low intensity interventions is less intensive than high intensity treatments; more precise details regarding the clinical interventions offered by PWP's during low intensity treatment, are provided later in the section. (IAPT 2011).

PWP's are explicitly trained and skilled in both 'common' and 'specific' therapeutic factors in order that they are able to establish, develop and maintain therapeutic alliances with clients, and to ensure they can effectively manage any potential or actual disruptions to this alliance. (IAPT 2011). PWP's are skilled in face to face and telephone work; the former is the primary method of therapy delivery for the trainees included in the current study.

As previously mentioned, the work is highly structured and very focused, and is 'high volume, low intensity'; workers within IAPT have fewer contacts but with a higher number of patients, and will for the most part spend less time in sessions than high intensity workers, with the average duration of a single contact being 35 minutes. Although the number of low-intensity sessions per client is not limited per se, the average duration of a course of treatment is between 6 and 8 sessions. Some practitioners may have ongoing contact with clients in order to assist with the management of chronic physical problems or with relapse prevention. (National IAPT programme, 2010).

Additional features of the PWP role include supporting clients with medication management and liaising with the client's GP regarding this if required. PWP's also work with health trainers, employment advisors and local community organisations to which they may signpost clients if this is deemed to be relevant and helpful. (National IAPT programme, 2010).

Determining whether a patient's experience of depression and/or anxiety is mild, moderate or severe is particularly important for a PWP. As previously highlighted, treatment (LICBT) should be targeted at those who are experiencing mild or moderate difficulties, as those with more severe, enduring and complex problems

need to be stepped up, and referred to higher intensity care. Although this distinction is not always very clear in practice, it can be judged to an extent, by considering the number, type and severity of symptoms, in addition to the information provided by formal diagnostic criteria and the information obtained from screening via routine outcome measures. (Papworth et al., 2013).

Another important aspect of the PWP role is the provision of supervision. PWP's are required to receive supervision both when in training and when qualified. They receive at least one hour per week of clinical case management supervision during which all patients on their caseload are reviewed at least once every four weeks. They also attend one hour per fortnight of clinical skills supervision which may be delivered in either an individual or group basis. Clinical supervisors are required to have a thorough understanding of the PWP role in addition to being skilled in delivering the relevant interventions themselves.

Furthermore, supervisors are required to have attended and successfully completed a low intensity supervisor training programme provided by an IAPT accredited training provider in order that their supervisee's can apply for individual accreditation. (IAPT, 2011).

2.3 A new service model in NI

The assessment interview schedule and the psychometric measures used by trainee PWP's are standardised as per the national curriculum for the training of low intensity cognitive behaviour therapists in keeping with IAPT guidelines. (IAPT, 2011; Richards and Whyte, 2011).

2.3.1 Clinical interview assessment interview

Conducting a standardised clinical assessment is a crucial part of the PWP role. An effective assessment should accurately identify the client's current presenting problem(s) and furthermore determine if the client is suitable for low intensity care. The term 'client' is used given that it is interpreted as more neutral in comparison with the term 'patient'. Moreover, evidence indicates the term is satisfactory to both service users and providers (Dickens & Picchioni, 2012; Simmons, Hawley, Gale & Sivakumaran, 2012).

It is essential that clients are provided with information about the service they are accessing including specific information about the role of a PWP and specific information about what LICBT involves. Clients should also be given clear information about the purpose of the clinical assessment before it begins in addition to information about confidentiality and informed consent.

This assessment interview is conducted by the PWP during the first session with the client. The pro forma used in session can be viewed in Appendix A. The demographic information collected includes the client's name, age, gender, contact information, employment status and marital status. The source of referral (referral method) is also recorded.

In order to screen for presence and severity of mental health difficulties, the initial questioning involves determining what the primary problem is, where it occurs, with whom the problem is better or worse, and when the problem happens. PWP's also attempt to capture specific examples of situations and stimuli which trigger the problem both in the present and stimuli which are triggered the problem in the past. The clients autonomic (physical), behavioural and cognitive symptoms are noted, in addition to the impact their difficulties have on work, home management, leisure, family life and relationships.

During each client contact a comprehensive risk assessment is also carried out to determine both the current and past level of risk which is defined as suicidal ideation, plans, behaviour, risk to others, neglect of self and others, and prevention (social network and access to services). If risk is detected, the remainder of the session focuses solely on the appropriate management of this.

Other important information gathered involves establishing why the patient wants help now and what their expectations and goals are comprised of. Details of past episodes of mental health difficulties are also noted as well as details of any other treatment being provided. The extent of drug and alcohol use (frequency, amount, type, when, where and with whom), is also explored. PWP's also provide support with managing medication(s).

Specifically this refers to determining if clients are taking/not taking medication(s) as prescribed, and subsequently determining the client's attitude towards this.

Practitioners may liaise with clients' GP's in relation to medication if necessary.

PWP's are required to adapt a client centred and collaborative approach, therefore a problem statement is agreed on by both practitioner and client before the assessment

is ended, and the PWP will ensure that the client understands a cognitive behavioural formulation of their own difficulties. Goals for treatment and treatment options are explored, and an agreement on plans, actions and arrangements for the second contact (if applicable) are made.

The purpose of the baseline interview is also to actually determine the client's suitability for low intensity cognitive behavioural therapy. As previously indicated, low intensity cognitive behavioural therapy is recommended as an intervention for mild to moderate mental difficulties, primarily depression and anxiety disorder as per NICE guidelines. The PWP may determine at this point that a client is unsuitable to continue with a course of low intensity treatment, if one of the following exclusion criteria is evident: a severe or enduring mood or anxiety disorder, significant current substance abuse, significant risk to self or others, psychosis, or significant trauma. Importantly if any of these become evident during the course of treatment, the PWP has a duty to discuss the issues with a clinical supervisor after which a decision is agreed regarding the client's suitability to continue with low intensity treatment. Clinical supervisors may recommend that a client is then stepped up to a higher intensity service. The client is informed about the decision and the recommendation and reasons for step up are put in writing for the attention of the source of the original referral i.e. the client's GP. The GP subsequently makes a referral to the more appropriate higher intensity service.

2.3.2 Identifying predictors of treatment outcome

Information gathered at assessment interview has been coded into quantitative data in order to achieve the aim of identifying predictors of treatment outcome. For the purposes of the research study, each trainee PWP completed a 'summary of research

document' which extracted relevant information from the assessment (see Appendix A) This ensured that each trainee within their cohort captured identical individual and service level information from each client. The information captured for the first cohort (2014/15) was not as detailed as subsequent groups. The tools used were revised to enable a more detailed service evaluation, specifically in relation to establishing employment status pre and post treatment, and in relation to whether medication was continued or discontinued following treatment completion.

General demographic information including gender, age and marital status was recorded for each client. Details of the remaining minimum data captured for every client within each year is described below.

- Referral method: PWPs were required to indicate if the client had been referred by their GP, Primary Care Team, or by the Talking Therapies Hub. Clients may also have self-referred in which case the PWP provided the referral details.
- Referral outcome: PWPs were required to indicate the outcome of the referral, which either resulted in the arrangement of an assessment interview, or not.
- Assessment outcome: PWPs were required to indicate the general outcome of the assessment interview. This resulted in the arrangement and attendance of a subsequent contact, the arrangement and non-attendance of a subsequent contact, a step up to a higher intensity service, or a referral to another low intensity service. It could also be the case that a client declined to arrange a subsequent contact following assessment.
- Employment status: The client's status at baseline was recorded for each cohort as either employed/full time student, retired, unemployed or on sick

leave. For the cohorts 2016/17 onwards, a discharge employment status was also recorded. This indicated of client's employment was either the same as baseline, or if they were planning to or had made a return to work.

- **Presentation:** This indicated the presenting problem as identified by the PWP following comprehensive biopsychosocial assessment. Primary presenting problems included depression, general anxiety, comorbid depression and anxiety, a specific phobia, panic disorder with agoraphobia, panic disorder without agoraphobia, health anxiety, post-traumatic stress symptoms, addiction issues or a specified other. The onset, (an indication of when the current problem began) was also indicated.
- **Risk:** A comprehensive risk assessment is conducted at each patient contact. PWPs specified the level of risk both currently and in the past in terms of suicidal ideation, plans, behaviour, risk to others, self-neglect, and neglect of others. 'Thoughts of life not worth living' was assessed precisely via item nine of the Patient Health Questionnaire which is also completed at each contact.
- **Medication:** The name(s) of medications the client has been prescribed were indicated in addition to their concordance with this i.e. if the client is taking the medication as prescribed or not. For the cohorts 2016/17 onwards, a discharge medication status has also been recorded. This indicated if the client had continued or discontinued medication by the end of the course of low intensity CBT treatment. If medication had been discontinued, PWPs indicated by whom this decision was made in addition to when and why.
- **Drugs and alcohol:** The level of drug and alcohol use declared by clients has also been recorded.

- Previous episodes: Any history or previous episodes of mental health difficulties were specified. This included depression, general anxiety, comorbid depression and anxiety, a specific phobia, panic disorder with agoraphobia, panic disorder without agoraphobia, health anxiety, post-traumatic stress symptoms, addiction issues or a specified other. Previous episodes referred to those which resulted in actual contact with health care services, and also included self-reported episodes where no previous contact with services was experienced.
- Other treatments: PWP's recorded if and what previous treatments for mental health difficulties clients previously availed of in addition to any other treatments currently being provided alongside the low intensity CBT.
- Outcome of final session: This information specified details of clients' circumstances at the time of their discharge from the PWP service. These included treatment completion, a step up to higher intensity service, a discharge due to receiving simultaneous high intensity treatment, discharged due to on-attendance, referred to another low intensity service or discharged as the client declined further sessions.

2.3.3 Modification of the clinical assessment interview for cohorts post April 2015

The ethical approval required in order to use clinical data for service evaluation purposes, and to carry out 4 month follow up interviews with clients, was obtained in April 2015. Therefore, PWP's in all years except those in the 2014/15 cohort, also provided information on research participation at assessment interview. The details for this cohort are as for the 2014/15 group. The PWP explains the purpose of the service evaluation and the protocol for the four month follow up interview. Clients

are given the information letter (see Appendix B), and a consent form (see Appendix C) for consideration, which they can complete in session or return during a subsequent contact.

2.4 PWP interventions

A number of treatments may be provided during a course of low intensity cognitive behavioural therapy by PWPs, in keeping with a stepped care approach. Several key factors have been highlighted in relation to the key components of effective treatment within stepped care IAPT services, and they must be adhered to by all practitioners including PWPs (Richards and Whyte, 2011; NCCMH, 2018).

Firstly, it is essential that treatment choice is informed and guided by the presenting problem identified at initial clinical assessment. CBT and LICBT in fact represent a wide range of therapies. For example LICBT or CBT for health anxiety is very different from the LICBT or CBT interventions that would be appropriate for social anxiety disorder. It is imperative therefore that practitioners work collaboratively with the clients in order to accurately and clearly determine the primary problem for which they are seeking help, prior to discussing treatment options or formulating a treatment plan. Moreover it is important that only NICE recommended interventions are offered. If the PWP determines that a client is suitable for LICBT, then this as the least intrusive of the treatments should be offered first as per a stepped care framework. It is necessary to discuss intervention options with clients and to subsequently involve them in the formulation of the treatment plan. Ideally individuals should not wait more than 6 weeks to access IAPT services; given that there is no formal IAPT model in NI, it is unclear how long each of the patients in the current study had been waiting since the point of initial referral. As indicated

earlier, PWPs have regular clinical case management and clinical skills supervision which, along with the collection of sessional routine outcome measures also supports appropriate ‘stepping up’ procedures.

More specifically this informs when there should be ‘stepping up’ in cases where there is no improvement, and stepping out when an alternative or no treatment becomes appropriate. As per procedures within English IAPT services, individuals may also be ‘stepped down’ from a high intensity service when a lower intensity approach becomes more appropriate.

In keeping with the IAPT service model, clinical care in the present study was organised according to a stepped care approach as per NICE guidelines. PWP’s are required to support clients to implement a range of low-intensity treatments. These refer to the ‘specific’ factors as opposed to the ‘common’ factors which encompass the maintenance of a therapeutic alliance, interpersonal communication and patient-centred questioning.

The clinical procedures implemented by PWP’s include behavioural activation, cognitive restructuring, exposure therapy, problem solving, managing panic, sleep hygiene, and medication support. Although this is not an exhaustive list of interventions, it does represent the core clinical procedures that PWP’s use with their clients.

2.4.1 Behavioural Activation

This is an effective treatment for depression in either high or low intensity formats. It works mainly by targeting the role of avoidance in depression, and subsequently on activities which can assist clients in re-establishing daily routines and in increasing pleasurable and necessary activities (Richards and Whyte, 2011). When people

experience depression they feel physically unwell, have negative thoughts and change both the frequency and type of their usual behaviours. Avoidance provides relief from what may be considered 'burdensome' consequently resulting in increased avoidance. Essentially the avoidant behaviour is 'negatively reinforced' Such avoidance also results in reduced opportunity for pleasurable and social activities thereby reducing positive reinforcement. (Farrand, Taylor, Greeves & Pentecost, 2013).

The six stages of behavioural activation include explaining behavioural activation to the client, identifying routine, necessary and pleasurable activities, making a hierarchy of difficulty according to the aforementioned identified activities, planning to do some of these activities, implementing the planned activities and finally continually reviewing progress. (Farrand, Taylor, Greeves & Pentecost, 2013).

2.4.2 Cognitive Restructuring

Cognitive restructuring is used in both depression and anxiety disorders, and refers to a way in which unhelpful and negative thoughts may be changed through identifying, examining and challenging them. A significant component of any emotional state is the thinking which is associated with the physical and behavioural symptoms. There are three stages to cognitive restructuring. Firstly clients must identify their thoughts, and more specifically the exact content of any unhelpful or negative thoughts, often referred to as 'hot' thoughts. Following this, clients should examine their thoughts in a more objective manner by collecting 'evidence' to support the accuracy or inaccuracy of them. The final stage requires the client to reconsider 'hot' thoughts according to the new evidence which has been gathered for

and against them after which these thoughts are reappraised and re-evaluated, resulting in the identification of alternative thoughts. (Richards and Whyte, 2011).

2.4.3 Medication Support

The purpose of medication support is to support clients to make the best decision on their medication use by gathering information on their attitude to medication, medication use, medication effects and side effects, by providing information regarding the appropriate use of medication and by negotiating shared decision on how clients use medications.

For the most part, PWP's support the patient's decision to follow (or not) the GP recommendations regarding medication, provided that it is made in a fully informed manner. The only circumstances in which a PWP should make an alternative and direct recommendation to a client regarding medication is if potentially harmful side effects are identified. In this case practitioners, must advise the client to temporarily discontinue use, inform the GP of the potentially dangerous side effects, strongly recommend their client make an urgent appointment to visit the GP and discuss the situation with a clinical supervisor as soon as possible. (Richards and Whyte, 2011).

2.4.4 Exposure therapy

This is a highly effective intervention for many anxiety disorders where avoidance has been determined as the key maintaining factor. People frequently strive to avoid situations or objects that they fear and such provides relief from the associated anxiety. However, the more people avoid, the more avoidance is used as a coping mechanism. This can result in long term difficulties whereby people find it increasingly difficult to confront their fears. (Richards & Whyte, 2011).

Exposure essentially involves the planned exposure of the client to their feared situation, object or context. It works via a process referred to as habituation which is the natural reduction in arousal achieved when people allow themselves to remain in the presence of a feared situation or object for a prolonged length of time. Over time anxiety levels will gradually reduce while the individual remains in the presence of the feared stimulus. With avoidance arousal is quickly reduced when an individual escapes from the feared stimulus.

However, the fear remains, and as a result an individual will experience similar arousal levels when encountering the feared stimulus again. In exposure therapy, habituation means that subsequent exposure will result in less anxiety than before (Richards & Whyte, 2011).

The four conditions necessary for effective exposure include grading (gradual confrontation), prolonged (there should be sufficient time in the presence of the feared stimuli in order for arousal levels to reduce), repeated (additional exposures of usually 4-5 per week are required to reinforce and maintain improvement), and without distraction (clients should feel some fear without engaging in safety behaviours in order to experience and consequently realise that fear reduces naturally in the presence of the feared stimulus). PWP's must help clients to compile a list of feared stimuli which should then be applied to a difficulty hierarchy. Exposure activities must begin at the lower end of the hierarchy and be practiced until habituation is achieved. Clients should be encouraged and supported throughout, and practitioners should assist clients in overcoming barriers by problem solving.(Richards and Whyte, 2011).

2.4.5 Problem Solving

Problem solving can be used when clients feel that their issues are too big to initially deal with. It adopts a very practical approach whereby clients are encouraged to take a step back from problems and think about what solutions may be possible.(Richards & Whyte, 2011). Problem solving is implemented by working systematically through seven steps including identifying the problem, identifying the solution, analysing the strengths and weaknesses, selecting a solution, planning the implementation, the actual implementation of the selected solution, and finally reviewing the outcome.(Farrand & Ford, 2012).

2.4.6 Managing Panic

According to DSM IV criteria (APA 1994), a panic attack is defined as a discrete period of intense fear or discomfort in which four or more of the following symptoms developed abruptly, peaking within ten minutes: palpitations, pounding heart or accelerated heart rate, sweating, trembling or shaking, sensations of breath shortness or smothering, feelings of choking, chest pain or discomfort, nausea or abdominal distress, feeling dizzy, unsteady, lightheaded or faint, derealisation or depersonalization, fear of losing control or going crazy, fear of dying, parathesias (tingling), chills or hot flushes.

By distinction, panic disorder, occurs when people experience recurrent or unexpected panic attacks and become fearful about the possibility of having further attacks and what they mean. Usually there is significant behaviour change whereby people frequently engage in avoidant behaviours in an effort to prevent attacks.

Panic disorder is defined relative to the presence or not of agoraphobia which occurs when individuals associate their panic attacks with specific places or situations.

(Chellingsworth & Farrand, 2011)

PWPs are required to gather detailed and personalized information in relation to panic attack symptoms and recommend the use of a panic diary. Clients must also be given information regarding the nature of anxiety symptoms and the ‘fight or flight’ response, to enable them to re-evaluate the meaning of symptoms. (Chellingsworth & Farrand, 2011)

2.4.7 Sleep Hygiene

This involves adhering to guidelines which promote more restorative and effective sleep, in addition to improved alertness throughout the day and overcoming issues regarding sleep at night. Sleep problems are extremely common features of depression and anxiety and providing information on sleep hygiene is an integral part of the PWP role. (Richards and Whyte, 2011). The steps followed by the PWP should include establishing the nature of the client’s difficulties (falling asleep, staying asleep, early waking, restless sleep, not feeling refreshed after sleep and worrying about sleep). Clients should be encouraged to keep a sleep diary and PWPs must provide information about normal sleep and the nature of sleep difficulties. (Richards and Whyte, 2011).

2.4.8 Goal Setting

This intervention is particularly recommended for use with clients who have co-morbid physical health difficulties or chronic conditions. (Richards and Whyte, 2011). Physical health difficulties can impose limitations on daily activity, requiring clients to think about different ways in which to achieve things by both setting and revising goals (Richards and Whyte, 2011). PWPs are advised to help clients set three goals according to the SMART acronym, meaning set goals should be specific, measurable, achievable, relevant, and time specific. Goals are then revised in session to enable a sense of achievement for the client (Farrand and Woodford, 2013).

2.4.9 Dealing with worry

This intervention is particularly recommended for use with clients for whom the primary symptoms indicate general anxiety disorder (Richards and Whyte, 2011). Excessive worrying can interfere with a person's ability to function effectively on a daily basis. People can feel trapped in a cycle of worrying that can make them feel irritable, physically tense and disrupt sleep. PWPs help clients distinguish between the two main types of worries which are practical (that we can act on), and hypothetical worries which are frequently 'what if' type thoughts about the future. People who worry excessively often find they have a lot of hypothetical worries which consequently interferes with the ability to address practical worries effectively (Chellingsworth, Farrand and Rayson, 2013). The intervention requires clients, with the help of their PWP, to record worries in a diary and make use of worry time as a technique to reduce worrying. (Chellingsworth, Farrand and Rayson, 2013).

2.4.10 Relapse Prevention

This procedure is recommended for use with clients when they are approaching the end of low intensity treatment. Specifically the PWP ensures the client can distinguish between a lapse and relapse. The practical workbook includes a written wellbeing plan, and strategies for maintaining CBT skills post treatment (Chellingsworth, Farrand and Small, 2013).

2.5 Routine outcome measures

In keeping with IAPT guidelines, psychometric measures are routinely collected during each patient contact including the assessment interview. As described in Chapter 1, one of the purposes of these is to gauge the severity of symptomatology and to monitor how scores fluctuate throughout the course of treatment, thereby monitoring patient progress. The two measures normally used with every patient attending low intensity services within IAPT were used in the current evaluation.

The PHQ-9 (see Appendix D), is used to measure the severity of depressive symptomatology. This is a nine item standardised measure which has been validated in a UK depressed population (Cameron, Crawford, Lawton & Reid, 2008). The scores range from 0 to 27 and it has good psychometric properties, (Kroneke, Spitzer & Williams, 2001) with a score of ten being the optimum indicator of clinically relevant depressive symptoms.

The GAD-7 (see Appendix E), has also been determined to have good psychometric properties having been validated in US populations. The scores range from 0 to 21 and a score of eight has been identified as the optimum indicator of clinically relevant symptoms of general anxiety disorder.

Although the GAD-7 was developed initially for the purpose of detecting general anxiety disorder only, it has adequate sensitivity and specificity to screen for post-traumatic stress, panic disorder or social anxiety disorder (Kroneke, Spitzer, Williams, Monahan & Lowe, 2007).

It is extremely important that client's feel involved and engaged with the process of completing ROMS and that they fully understand the purpose and benefits of this (RCP, 2013; Richards & Whyte, 2011; Vail et al., 2012). For these reasons it is essential that practitioners are mindful that any social, language or cultural barriers are addressed (Rau et al., 2010; Richards & Whyte, 2011).

Clients can feel motivated, reassured and encouraged when observing how their scores decrease throughout treatment (Young, Kraus & Castonguay, 2012), and evidence suggests that clients generally do feel positive about the use of measures (Gellatly, 2011; Unsworth, 2015). Furthermore qualitative evidence suggests that practitioners find ROMS to be a helpful way of validating their own skills (Steen, 2015).

2.6 Design

This study has a longitudinal design, whereby individuals undergo a course of low-intensity cognitive behavioural therapy for mild to moderate level depression and/or anxiety, delivered by a trainee psychological wellbeing practitioner.

2.6.1 2014/2015 cohort

For the 2014/15 cohort, the treatment included an initial assessment (baseline) interview which involved determining the nature and severity of psychological difficulties in addition to a detailed social and background profile.

The duration of LICBT treatment ranged from 1 to 11 sessions. Follow up data was not collected from the 2014/15 cohort; participant consent for this particular arm of the study was not sought until ethical approval was granted (see section 2.9 for details on ethical approval). This was obtained in April 2015, by which time these patients had been discharged from services.

2.6.2 2015/2016 and 2016/2017 cohorts

For subsequent cohorts, the treatment included an initial assessment (baseline) interview which involved determining the nature and severity of psychological difficulties in addition to a detailed social and background profile. The duration of LICBT treatment ranged from 1 to 11 sessions. In order to assess the longer term benefits of treatment follow up data was also collected from these cohorts. At approximately four months post discharge (specifically no later than 4 months and 14 days from the date of the final session), the PWPs contacted the patient again where consent had been obtained. During this follow up interview, psychometric measures, specifically the PHQ-9 and the GAD-7 were collected again.

2.7 Sampling and settings

Referrals were received by the trainee PWPs at their placement sites (details outlined below). NHS and community services throughout Northern Ireland which provide psychological talking therapies and counselling were contacted, and those willing and able to facilitate the trainee PWPs were selected as the placement sites.

Sources of referrals include the prospective patient (self-referral) or their GP.

Additional referrals were also be received from the Primary Care mental health team or from the Talking therapies Hubs. Detailed information on the sample for those who participated in the quantitative evaluation, is provided in Chapters 3 and 4.

This was a multi- site study given that trainee PWPs were assigned to a number of different health care sites which facilitate the delivery of psychological therapies.

Please see figure 2.1 outlining referral and treatment pathways.

Details of sampling within each placement site are indicated, more specifically details of referral method, the outcomes of initial referral, the number of clients attending at least 2 sessions and details of follow up eligibility and completion (see tables 2.1-2.7.)

2.7.1 Healthy Living Centre

This is a community based wellbeing centre which offers a range of wellbeing interventions and courses. It is located in the Creggan area of Derry City which has historically been an area of high socioeconomic deprivation. Facilitators regard the Centre as a site of restorative healing within which members of the local community are supported to take control of their own health and wellbeing. The key areas within which services are directed include enabling access to primary care at a community level and supporting people with mental health difficulties.

Referrals to the centre were initially received by the manager, who subsequently forwarded potentially suitable clients to the trainee PWP(s) on site. The centre facilitates self-referrals and receives further referrals for low intensity interventions from local GPs. Initial assessment interviews were arranged by the PWPs.

2.7.2 CALMS

This is a community based wellbeing centre located in Derry City Centre. CALMS is an acronym for Community Action for Locally Managing Stress. Approaches to health and wellbeing focus on prevention and rehabilitation. Services offered include counselling, psychological therapies and complimentary therapies.

Referrals to the centre were initially received by the manager, who subsequently forwarded potentially suitable clients to the trainee PWP on site. The centre facilitates self-referrals and receives further referrals for low intensity interventions from local GPs. Initial assessment interviews were arranged by the PWPs.

2.7.3 The Koram Centre

The Koram Centre is a registered charity which offers counselling, psychological therapies, psycho-social support and complementary therapies. The Centre is located in Strabane, Co Tyrone in an area of relatively high socioeconomic deprivation.

Referrals to the centre were initially received by the manager, who subsequently forwarded potentially suitable clients to the trainee PWP(s) on site. The centre facilitates self-referrals and receives further referrals for low intensity interventions from local GPs. Initial assessment interviews were arranged by the PWPs.

No trainee PWPS from the 2016/17 cohort were based at this site, as centre managers were unable to facilitate a placement during this time.

2.7.4 Foyleside Family Practice

This is a GP practice in Derry City Centre within which four GPs are based.

Referrals were received directly from the GPs and initial assessment interviews were arranged by the administration staff on site according to PWP availability.

2.7.5 Bridge Street Practice

This is a GP practice in Derry City Centre at which four GPs are based .Referrals are received directly from the GPs and initial assessment interviews were arranged by the PWP.

2.7.6 Western Trust

This is a Northern Ireland based National Health Service Trust serving the geographical range, which covers the local council areas of Derry, Limavady, Omagh, Strabane and Fermanagh. The Western Trust provides integrated health and social care to a population of approximately 294,000 in these areas. Primary Care Level services at which trainee PWPs were placed received referrals from local GPs. Clinical supervisors on site then determined which clients were subsequently potentially suitable for low intensity work, and thereby a referral to the PWP on site.

2.7.7 Belfast Trust

This is a Northern Ireland based National Health Service Trust serving the geographical range, which covers the Belfast area and part of the Borough of Castlereagh. The Belfast Trust delivers integrated health and social care to approximately 340,000 people these locations. Primary Care Level services at which trainee PWPs were placed received referrals from local GPs. Clinical supervisors on site then determined which clients were subsequently potentially suitable for low intensity work, and thereby a referral to the PWP on site.

No data was collected from this site during the 2016/17.

2.7.8 Southern Trust

This is a Northern Ireland based National Health Service Trust which provides integrated patient / client centred services to a population of 365,712 people in the geographical range including Armagh, Banbridge, Craigavon, Dungannon, South Tyrone, Newry and Mourne. Primary Care Level services at which trainee PWPs were placed received referrals from local GPs. Clinical supervisors on site then determined which clients were subsequently potentially suitable for low intensity work, and thereby a referral to the PWP on site.

No trainee PWPS from the 2016/17 cohort were placed at this site. Clinical supervisors at the site were not able to facilitate a trainee placement in this year.

2.7.9 Aware

This is a mental health charity run community organisation. They provide support for individuals living with depression and bipolar disorder, specifically offering counselling and support group services. They have premises in both Derry City and Belfast.

Referrals to the centre were initially received by the manager, who subsequently forwarded potentially suitable clients to the trainee PWP(s) on site. The centre facilitates self-referrals and receives further referrals for low intensity interventions from local GPs. Initial assessment interviews were arranged by the PWPs.

2.7.10 People Plus

This is an employability, training and recruitment service located in Coleraine, Co. Derry. The service users here are comprised primarily of long-term unemployed individuals who are seeking to secure sustainable employment.

The trainee PWP on site delivered low intensity CBT interventions to those service users determined as having a mild to moderate level mental health difficulty. PWPs are required to liaise with community sector parties including employment and recruitment services, in order to assist clients who wish to make a return to employment.

This placement was secured in 2016/17, and so is therefore included in the evaluation for this cohort only.

2.7.11 Men's Action Network

Men's action network is a charity funded community sector organisation located in Derry city centre, the stated aim of which is "Supporting and Promoting the Health and Well-being of men in the North West of Ireland." The service seeks to promote community self-help initiatives among local men by providing information on relevant issues regarding men's health and wellbeing, and by providing support in times of crisis. The primary focus of work is on prevention and intervention in relation to emotional, physical, mental, spiritual and social life experiences. This placement was secured in 2016/17, and so is therefore included in the evaluation for this cohort only.

Table 2.1 Details of referral method for 2015 group

		GP	Self	Primary Care Team	Hub	Employment Consultant	Total
PWP placement site	Healthy Living Centre	18	10	0	0	0	28
	Foyleside Family Practice	10	0	0	0	0	10
	Bridge Street Practice	13	0	0	0	0	13
	Koram Centre	0	5	0	0	0	5
	Calms	9	0	0	0	0	9
	Belfast Trust	7	0	0	0	0	7
	Western Trust	16	0	0	0	0	16
Total		73	15	0	0	0	88

Table 2.2 Details of referral method for 2016 group

		GP	Self	Primary Care Team	Hub	Employment Consultant	Total
PWP placement site	Healthy Living Centre	10	6	3	0	0	19
	Foyleside Family Practice	9	0	0	0	0	9
	Bridge Street Practice	8	0	0	0	0	8
	Korum Centre	20	1	0	0	0	21
	Calms	9	1	0	0	0	10
	Belfast Trust	1	0	12	0	0	13
	Western Trust	1	0	1	0	0	2
	Southern Trust	5	0	0	0	0	5
	Aware Derry	0	7	0	0	0	7
	Aware Belfast	0	12	0	0	0	12
Total		63	27	16	0	0	106

Table 2.3 Details of referral method for 2017 group

		Primary				Employment	
		GP	Self	Care	Hub	Consultant	Total
PWP placement site	Foyleside Family Practice	5	0	0	1	0	6
	Bridge Street Practice	5	0	0	0	0	5
	Calms	4	0	0	7	0	11
	Western Trust	1	0	2	10	0	13
	Aware Derry	0	2	0	1	0	3
	Men’s Action Network	8	4	0	2	0	14
	People Plus N.Irl	0	0	0	0	2	2
Total		23	6	2	21	2	54

Table 2.4 Frequencies of clients treated by the 2015 group who attended at least two sessions

		next contact agreed and attended	next contact agreed but didn't attend	stepped up to higher intensity service	referred to another low intensity service	client declined further sessions	Total
PWP placement site	Healthy Living Centre	22	5	0	1	0	28
	Foyleside Family Practice	8	2	0	0	0	10
	Bridge Street Practice	8	4	0	0	1	13
	Korum Centre	5	0	0	0	0	5
	Calms	6	3	0	0	0	9
	Belfast Trust	7	0	0	0	0	7
	Western Trust	16	0	0	0	0	16
Total		72	14	0	1	1	88

Table 2.5 Frequencies of clients treated by the 2016 group who attended at least two sessions

		next contact agreed and attended	next contact agreed but didn't attend	stepped up to higher intensity service	referred to another low intensity service	client declined further sessions	Total
PWP placement site	Healthy Living Centre	17	2	0	0	0	19
	Foyleside Family Practice	9	0	0	0	0	9
	Bridge Street Practice	8	0	0	0	0	8
	Korum Centre	19	1	1	0	0	21
	Calms	10	0	0	0	0	10
	Belfast Trust	18	0	0	0	0	18
	Western Trust	2	0	0	0	0	2
	Southern Trust	5	0	0	0	0	5
	Aware Derry	7	0	0	0	0	7
	Aware Belfast	11	0	0	0	1	12
Total		106	3	1	0	1	111

Table 2.6 Frequencies of clients treated by the 2017 group who attended at least two sessions

		next contact agreed and attended	next contact agreed but didn't attend	stepped up to higher intensity service	referred to another low intensity service	client declined further sessions	Total
PWP placement site	Foyleside Practice	5	1	0	0	0	6
	Bridge Street Practice	5	0	0	0	0	5
	Calms	11	0	0	0	0	11
	Western Trust	12	0	0	1	0	13
	Aware Derry	3	0	0	0	0	3
	Men's Action Network	14	0	0	0	0	14
	People Plus N.Irl	2	0	0	0	0	2
Total		52	1	0	1	0	54

Table 2.7 Details of follow up completion for 2015 group

		follow up completed	client uncontactable	consent not obtained	Total
PWP placement site	Healthy Living Centre	0	0	28	28
	Foyleside Family Practice	0	0	10	10
	Bridge Street Practice	0	0	13	13
	Korum Centre	0	0	5	5
	Kalms	0	0	9	9
	Belfast Trust	1	0	6	7
	Western Trust	0	0	16	16
Total		1	0	87	88

Table 2.8 Details of follow up completion for 2016 group

		follow up completed	client uncontactable	consent not obtained	Total
PWP placement site	Healthy Living Centre	7	3	9	19
	Foyleside Family Practice	7	2	0	9
	Bridge Street Practice	5	2	1	8
	Korum Centre	0	0	21	21
	Kalms	6	4	0	10
	Belfast Trust	1	7	10	18
	Western Trust	1	0	1	2
	Southern Trust	0	5	0	5
	Aware Derry	6	1	0	7
	Aware Belfast	3	3	6	12
Total		36	27	48	111

Table 2.9 Details of follow up completion for 2017 group

		follow up completed	client uncontactable	consent not obtained	Total
PWP placement site	Foyleside Practice	1	4	1	6
	Bridge Street Practice	0	3	2	5
	Calms	2	9	0	11
	Western Trust	4	7	2	13
	Aware Derry	2	1	0	3
	Men's Action Network	5	9	0	14
	People Plus N.Irl	0	2	0	2
Total		14	35	5	54

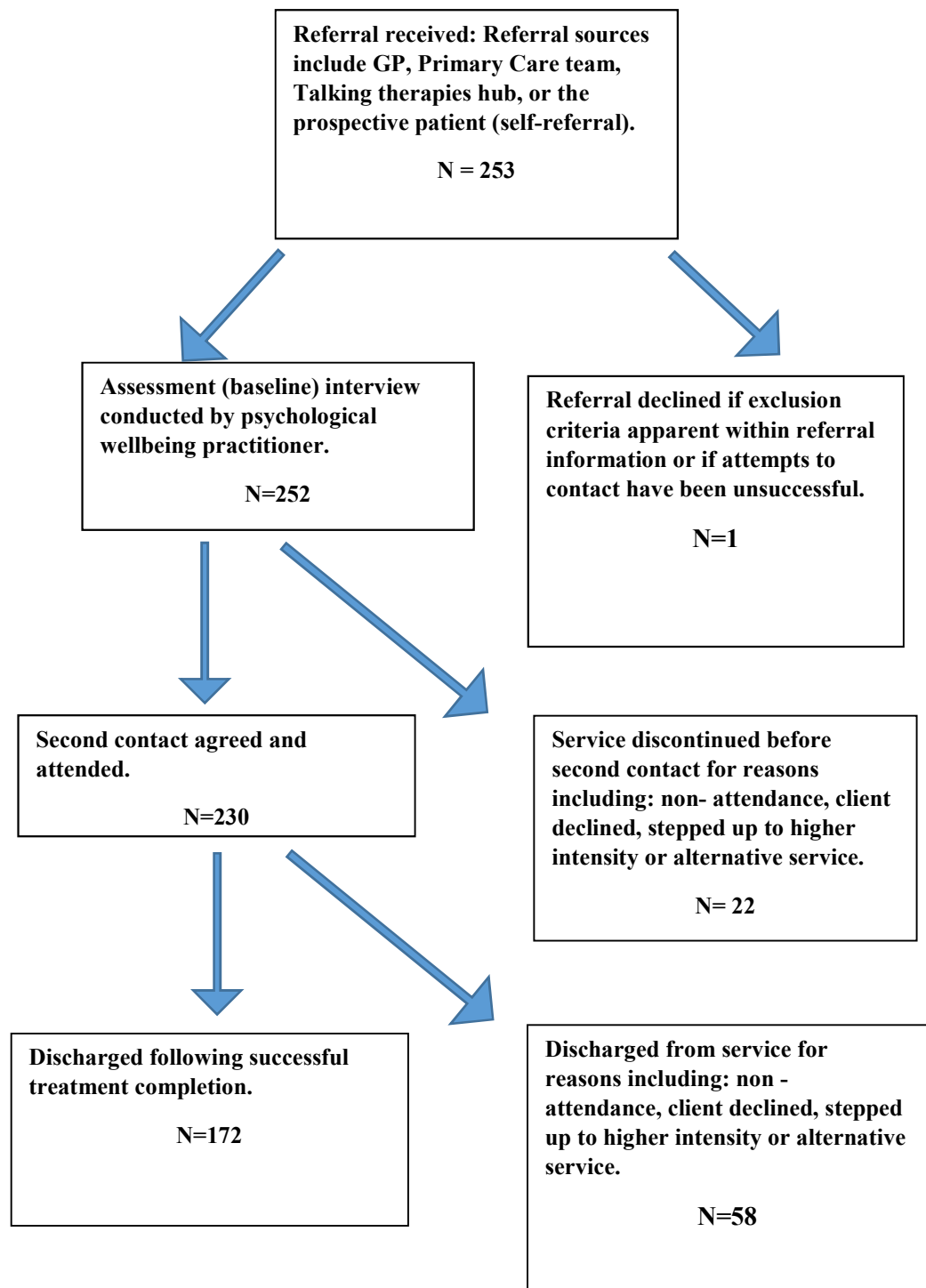


Figure 2.1 Consort diagram indicating pathways from point of referral to treatment end.

2.8 Ethical Approval

Ethical approval was obtained from Ulster University Ethics Committee with regards to the data collection from community based trainee placement settings. Specifically this included the Healthy Living Centre, Aware, Calms and the Korum Centre. A subsequent ethical procedure was undertaken in relation to the Health Trusts. This was managed via the Integrated Research Application System (IRAS), within which applications were made to Clinical Research Governance within the Southern, Belfast and Western Trusts. Placement facilitators were subsequently provided with information sheets and consent forms (see Appendix F). Consent was explicitly given for fully anonymised patient data (completed psychometric questionnaires) to be included in the evaluation of treatment effectiveness. Patients were also provided with information sheets and provided additional consent to be contacted by their PWP approximately four months post treatment. (see Appendix B and Appendix C). All ethical procedures were completed by April 2015 when approval for all sites was obtained via IRAS (see Appendix G) and the Office of Research Ethics Committee (ORECNI) (see Appendix H). Therefore, as outlined earlier within details of design, follow up data was collected only for patients treated by PWPs from the 2015/16 and 2016/17 cohorts. A notice of ‘substantial amendment’ was submitted to the IRAS committee in 2018 in relation to the qualitative arm of the study which explored the perspectives of selected service providers who facilitated the trainee PWP placements (see Chapter 5). This amendment was subsequently approved in April 2018 (see Appendix I). PWP service providers were invited to participate and given an information sheet (see Appendix J), and a consent form (see Appendix K).

2.9 Plan for data analysis

Quantitative evaluations of the PWP service are carried out by determining reliable change in clients' symptoms, specifically reliable recovery, deterioration and improvement (see Chapter 3 methodology). Further evaluations identify individual and service level variables which may predict treatment outcomes using a growth mixture modelling method (see Chapter 4 methodology). Additional analysis of longitudinal data examines reliable change in symptomatology as indicated by psychometric measures collected four months post treatment, in order to evaluate the longer term effectiveness of the intervention (see Chapter 3). A qualitative analysis will also examine the views of service providers in relation to how the PWPs may or may not have improved access to psychological therapies at the primary care level (see Chapter 5 methodology). The final empirical chapters (6 and 7), considers a patient sub-population who might also benefit from access to a PWP service. The particular methodologies include service needs analysis and a systematic review. More specifically this involves determining the prevalence of non-cardiac chest pain with possible associated anxiety within an emergency department, and reviewing the evidence for appropriate low intensity psychological interventions.

2.10 Dataset

The given title of the SPSS (version 23) data file is "Northern Ireland psychological wellbeing practitioner service 2014-2017." Details of all variables and value labels are provided (see Appendix L).

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Chapter 3

Reliable change: improvement, recovery and deterioration

A brief version of this chapter has been published in the Journal of behavioural and cognitive psychotherapy:

McDevitt-Petrovic, O., Kirby, K., McBride, O., Shevlin, M., McAteer, D., Gorman, C., & Murphy, J. (2018). Preliminary Findings of a New Primary and Community Care Psychological Service in Northern Ireland: Low-Intensity Cognitive Behavioural Therapy for Common Mental Health Difficulties. *Behavioural and cognitive psychotherapy*, 1-7.

Chapter Overview

The focus of the current chapter is the initial evaluation of a new primary and community care psychological service in Northern Ireland. More specifically this service model facilitated the provision of low intensity cognitive behavioural therapy treatments for mild to moderate level mental health difficulties, primarily depression and anxiety. Interventions were delivered by trainee psychological wellbeing practitioners who completed accredited training at Ulster University as described in Chapter 2. The service model was designed and implemented as per the IAPT programme in England.

The chapter discusses some of the evidence supporting the clinical effectiveness of the IAPT model, thereby clarifying why it is a useful service model to evaluate in Northern Ireland given the gaps in service provision there, and the importance of

service delivery in a local context. The clinical outcomes reported in the current chapter focus on the reliable improvement, deterioration and recovery rates following LICBT for the entire sample of clients 2014-2017. Furthermore, the longer term effectiveness of the intervention will be examined. Specifically, this will determine if treatment gains, namely reliable improvement and recovery, were maintained four months post treatment.

3.1 Introduction: evidence for the effectiveness of the English IAPT model

As detailed in Chapter 1, the rationale for the substantial government investments into the IAPT initiative and the subsequent widespread implementation, was based on both clinical and economic recommendations. (Clark et al., 2009). Following the success of the pilot sites, the Department of Health released a 'National Implementation Plan' in 2008 facilitating the establishment of IAPT services in all areas of England across a six year period as described in Chapter 1.

The importance of routine outcome measures, and the detailed monitoring of these for continuing evaluations are a fundamental element of the IAPT programme. The initiative requires a minimum dataset whereby a record of care is kept for each service user detailing their progress throughout the course of treatment. As with the pilot evaluations, a session by session monitoring protocol is used in order to retain high levels of post data completeness. This ensures that every service user has a clinical endpoint even where treatment is discontinued before expected.

The clinical and economic gains directly associated with IAPT in the first three years include recovery of almost 250000 clinical cases (45%), and almost 45000 individuals moving off benefits (Clark, 2011). Recovery rates increased steadily

from 17% to 45% throughout the first three years, in keeping with the predictions which followed the pilot sites.

Gyani, Shafran, Layard and Clark (2013), examined year one IAPT data across 32 IAPT services with an aim to report on reliable recovery rates, individual and service level predictors of recovery, and associated compliance with NICE guidelines. Identifying predictors of treatment response is important both in terms of defining new treatment targets, and in order to further understanding about how existing interventions may be more usefully applied. Data from up to 19,395 service users was analysed. Patients were required to have ‘caseness’ at initial assessment interview and were required to have completed at least two sessions of treatment. ‘Caseness’ refers to a score above the clinical cut off on one or both of the routine outcome measures used in each session, namely the PHQ-9 and GAD-7 which assess depressive and anxiety related symptomatology respectively. Further details on caseness and the routine outcome measures are outlined in the methodology section of the current chapter. The majority (91.4%) of the service user cohort in this analysis met these above described criteria.

The criteria used within the recovery index which is subsequently used to determine reliable recovery, reliable improvement and reliable deterioration is also described in the methodology section of the current chapter. Overall, 40.3% of patients achieved reliable recovery 63.7% demonstrated reliable improvement, and 6.6% showed reliable deterioration. Rates varied significantly between services.

A significant negative correlation between improvement and deterioration indicated that services in which fewer patients had improved simultaneously had a greater proportion of service users who had deteriorated.

The low intensity therapies offered consist of either guided self-help or pure self-help, with the majority in this case receiving guided self-help. Gyani et al (2013) concluded that guided self-help was a significant predictor of reliable recovery where the diagnosis was depression, general anxiety or comorbid depression and anxiety. More specifically, those who received guided self- help versus pure self - help for a depressive episode were 3.19 times more likely to recover. This was also the case with diagnoses of general anxiety and comorbid depression and anxiety whereby patients receiving guided as opposed to pure self-help were 2.6 and 2.1 times more likely to recover respectively. Moreover, the percentage of service users who were stepped up to a higher intensity service following guided self-help was 25.7, compared to a figure of 54.5 for those who received pure self- help, which lends further support to the superior efficacy of guided self-help. An integral part of the IAPT initiative is the drive to improve access to NICE recommended psychological treatments for anxiety and depression (Department Of Health 2008). Considering low intensity treatments with regard to the data from the first year, the above mentioned findings were in keeping with NICE recommendations whereby guided self-help but not exclusive self-help is advocated for depression.

The focus on LI interventions is central to the IAPT service model as it enables treatments to be delivered to a high volume of clients with faster access. However it has also been posited that that such a focus may also result in some clients being referred inappropriately for LI treatments due to insufficient assessment (Cairns, 2014; Di Bona, Saxon, Barkham, Dent-Brown & Parry, 2014).

When the use of stepped care within one IAPT service was evaluated no difference in baseline treatment scores were determined (Chan & Adams, 2014).

Gyani et al . (2013) did determine that a higher step up rate was associated with increased recovery in IAPT services. However the implementation of the approach varied between sites; across four IAPT services the proportion of clients referred initially to high intensity care ranged from 3% to 45%, and the rate of step up rarely exceeded 10% (Richards et al., 2012), suggesting the self-correcting mechanism (Bower & Gilbody, 2005) was possibly underused in some IAPT services.

By 2013, IAPT clinical services were treating approximately 400,000 individuals annually; almost half of these had reliably recovered by the end of treatment (Layard and Clark 2015). More recently published figures indicate that 51% of eligible referrals within IAPT services, achieved recovery criteria, with rates therefore remaining above the national target of 50% (HSC, 2017).

More recent research using a sample of patients treated by a PWP delivering low intensity interventions across the first three years of IAPT, found that more than two thirds had reliably improved depression and anxiety symptoms by the end of treatment (Branson, Myles, Mahdi & Shafran, 2018).

The IAPT initiative has also been demonstrated to have important cost benefits. The estimated average cost for a low intensity session and course of treatment was £99 and £493 respectively. These estimates are supportive of the originally proposed IAPT programme on cost-benefit grounds (Layard, Clark, Knapp & Mayraz, 2007; Radhakrishnan, Hammond, Jones, Watson, McMillan-Shields, & Lafortune, 2013).

As previously highlighted, the rationale for nationwide implementation has also been motivated by the potential economic gains associated with increased productivity and re-employment (Layard et al., 2007).

3.1.1. Longer term effectiveness of LICBT

The differences between relapse (deterioration following initial positive treatment response), and recurrence (a new episode of symptoms or period of difficulty following a period of recovery), have been highlighted within mental health and psychological interventions research (Bockting, Hollon, Jarrett, Kuyken & Dobson, 2015). Depression has a relatively high recurrence rate; specifically, the likelihood of a second recurrence after an initial episode is approximately 50%, increasing to 70% following two episodes, and increasing to 90% following three episodes (Burcusa & Iacono, 2007). Similarly, high rates of recurrence have also been determined for individuals with anxiety disorders (Bruce et al., 2005; Vervliet, Craske & Hermans, 2013). Studies have found that CBT reduces the risk of relapse in depression compared with medication (Cuijpers et al., 2013; Vittengel, Clark, Dunn & Jarrett, 2007), and is associated with maintenance of recovery in a number of anxiety disorders (Otto, Smits & Reese, 2005).

Although the clinical effectiveness of LICBT has been established when considering baseline and end of treatment symptom severity, as per reliable symptom change criteria, less is known about the longer term effectiveness, and whether the benefits achieved during treatment are maintained. Findings to date have been mixed.

Andrew, Cuijpers, Craske, McEvoy and Titov, (2010) found that following a course of LICBT for depression or anxiety, reliable improvements were maintained at follow ups (averaging 26 weeks), without indication of relapse.

However, a recent investigation of the enduring effectiveness of LICBT determined that clinical improvements were not maintained at a 12 month follow up in 50% of cases (Ali et al., 2017). They have suggested that patients should be offered post treatment follow up booster sessions (Gearing, Schwalbe, Lee & Hoagwood, 2013),

and that further work must be done in regard to relapse prevention following LICBT in routine stepped care services.

3.1.2 Effectiveness of Self-referral

Previously, concerns regarding self-referral pathways were raised, namely that they may cause certain services to feel overwhelmed, or that they may favour certain types of client (Brown et al., 2010; IAPT, 2008a; Mathers & Mitchell, 2010); evidence to date however, indicates that this is not the case (Brown et al., 2014; Clark et al., 2009; Gaynor & Brown, 2013). It has also been suggested that self-referral pathways might bypass the function of other important healthcare workers such as GPs, although as discussed earlier, self-referral has actually been found to improve treatment access among those who tend to be underrepresented in GP referrals (Gyani et al., 2013; Lovell et al., 2014).

Regardless of how different referral pathways operate, the collaboration and expertise of other professionals is essential, and the benefits of this support has been highlighted following the implementation of IAPT services (Gyani et al., 2013; Knowles et al., 2013; Stern, Hard & Rock, 2015). Moreover, increased awareness and focus on NICE recommended evidence based interventions among GPs has been furthermore associated with improved access to IAPT services (Gyani et al., 2013).

3.2 Improving access to low intensity care in Northern Ireland

Although the efficacy of early interventions such as low intensity cognitive behavioural therapy (LI-CBT) are the most strongly evidenced with depression and anxiety, and although such approaches are shown to save money in the long term (Layard et al., 2007), a stepped care model has not yet been fully established in NI (Blane, Williams, Morrison, Wilson & Mercer, 2014). Psychological therapy service

provision in NI has tended to focus on the more complex end of the spectrum of mental health difficulties, and consequently, educational and professional training has similarly concentrated largely on individuals working at these levels, as described in Chapter 1.

Notably, the Northern Ireland Mental Health Services Thresholds Criteria in 2013, acknowledged that low intensity therapists are crucial if we are to implement a more firmly established and effective stepped care approach to psychological therapy provision in the province. (HSC, 2014).

Poor and unequal access to timely and suitable care has historically been linked with a lack of clear service delivery models, weak leadership, undertrained practitioners and inadequate government support (McManus et al., 2009; Seward & Clark, 2010). Inadequate state provision results in costs becoming an individual's own responsibility which consequently increases financial burdens, and perpetuates a vicious cycle of difficulty (Patel et al., 2007). It may be argued that there isn't a need to evaluate the effectiveness of LICBT in a NI context; can it not be assumed given the positive outcomes in England that this would be the case elsewhere? It is clear however that local area context can significantly impact service delivery (Byng et al., 2011; Sharp, Dickson & Whittington, 2014). Therefore, whilst in NI much can be learned from the general national IAPT model in England, it is important to acknowledge that service provisions there are adapted in order to reflect need at a local level. Several important factors have influenced the implementation of local IAPT services in England including geographical location, transport, links to other services and casemix; services are thereby refined in accordance with the needs of their respective catchment areas, further highlighting the impact of many

sociodemographic factors on mental health (Clark et al., 2009; Glover et al., 2010; IAPT, 2008; Richards et al., 2012; Sharp et al., 2014).

3.3 Aims

Considering the evidence presented above and the recommendations discussed in Chapter 1, it is clear that the current provision of psychological therapies at the Primary/Community Care Level in NI is in its early stages of development, with few empirical evaluations to date of the effectiveness of treatment approaches at this level. Indeed, the recent DH report in (2016) indicated that the improvement of access to psychological services has been wholly inadequate and significant funding is required to match that which is being offered in England. Hence, there is a need to provide evidence of a service model that works and can be implemented effectively in NI.

The main objective of the current chapter is to present the findings of an evaluation of changes in clients' symptoms after a course of LI-CBT for common mental health difficulties delivered by trainee PWPs working directly with three of the newly established 'Primary care Talking Therapies Hubs' and other primary care (GP practices) and community care settings in an NI context. Specifically, this evaluation predicted that following a course of LI-CBT, there would be a reduction in PHQ-9 and GAD-7 scores to normal range below clinical thresholds, and that these findings would be in keeping with existing IAPT UK outcomes, thereby providing initial evidence that the IAPT service model is effective in a Northern Ireland context.

Furthermore it was predicted that of those clients who completed the PHQ-9 and GAD-7 at a four month follow up point post treatment, the majority would maintain the gains achieved during treatment.

3.4 Methodology

3.4.1 Design

This was a prospective pilot study following a cohort of participants (N=253) from baseline (before commencement of therapy), through the course of LI-CBT weekly treatment (1-11) sessions, and at discharge (final session of treatment). This study is limited to examining changes in psychological status in participants before and after therapy. The second arm of the study involves examining changes in psychological status between the treatment end point and a four month follow up point.

3.4.2 Sample and settings

Data from a total of 253 clients who were referred to a trainee PWP were gathered between 2014 and 2017. The findings reported in the current chapter include only the clinical outcomes for clients who met the inclusion criteria for ‘caseness’ which is described in full below (see 3.4.4). A total of 211 referrals were subsequently determined as ‘case’ clients, of which there were 122 females and 89 males. Ages ranged between 19 and 70 with a mean age of 41 (SD= 14.21). Data were gathered from a total of twelve sites within which PWPs completed clinical placements, as indicated in Chapter 2. A total of 120 case clients were treated at community organisations and 93 were treated in an NHS primary care setting. The demographic characteristics of the sample meeting caseness criteria are presented in Tables 3.1.

Of the 211 clients meeting caseness criteria, 108 (51.2%) were eligible to provide consent to participate in follow up data collection 4 months after treatment. The remaining case clients (n=103, 48.8%) were ineligible to provide consent. This was due to a number of reasons, namely that it took longer to obtain ethical approval in relation to follow up data collection (n =83), and because consent for follow ups was withheld by one clinical placement site (n= 17). Furthermore, some clients were ineligible due to treatment incompleteness and subsequent step up referral (n=3). The majority of case clients who were eligible to provide consent for follow-ups did so (n=103, 95.3%). Follow up data was successfully gathered from 45 (43.6%) of these clients; data was not gathered from the remaining clients as they were subsequently not contactable at the four month follow-up point. Of those with complete data, 55.6% were female, and 44.4.% were male. Ages ranged from 18 to 77, with a mean age of 37 (SD=13.6).

Table 3.1 Demographic characteristics of case clients at point of assessment

Characteristic	n	%
Gender		
Male	89	42.2
Female	122	57.8
Marital Status		
Married/in relationship	103	48.8
Single	108	51.2
Employment Status		
Employed or in full time study	105	49.8
Unemployed	86	40.8
Retired	12	5.7
On sick leave	7	3.3
Redundancy	1	0.5
Age Range		
<20	16	7.6
21-30	60	28.4
31-40	52	24.6
41-50	38	18
51-60	26	12.3
61-70	14	6.6
71-80	1	0.5
Referral Method		
GP	131	62.1
Self	40	19
Primary Care Team	16	7.6
Talking Therapies Hub	18	8.5
Employment Consultant	1	0.5

* missing data: age range (n=4), referral method (n=5),

3.4.3 Procedural details

Studies which aim to evaluate the effectiveness of clinical services, frequently have a substantial amount of missing data, particularly at the post-treatment phase. For this reason, previous evaluations of IAPT clinical sites have employed a session by session outcome monitoring method. This facilitates high levels of data completeness as found by the pilot demonstration sites in Doncaster and Newham (Clark et al 2009; Richards & Suckling 2009). More specifically, 99% and 88% of clients in Doncaster and Newham respectively, who completed at least two sessions, had pre and post treatment scores on the PHQ-9 and GAD-7. The last available session scores were used as post treatment data for those who finished treatment earlier than expected.

In addition to using the session by session monitoring system, the IAPT pilot demonstration sites also utilised a more traditional data collection method, and recorded pre and post treatment scores based on the CORE-OM (Barkham et al., 2001). This resulted in lower levels of data completeness (6% and 54% in Doncaster and Newham respectively), which was largely due to missing post treatment scores. Furthermore, the session by session monitoring of the PHQ-9 and GAD-7 scores, indicated that patients who did not provide post treatment data with the CORE-OM showed less than half the improvement than those who did. As a result of this, the IAPT national team concluded that services with high levels of missing data are likely to overestimate their effectiveness.

3.4.4 Caseness Criteria

In keeping with IAPT recommendations, the clinical outcomes reported here are related only to clients who met caseness criteria (Gyani et al., 2013). This means they will have had at least two contacts with a PWP, and will therefore have completed an initial assessment interview and at least one session of treatment.

The clinical outcomes of clients who were deemed unsuitable at either the point of referral or following an assessment interview will not be reported. It is very unlikely that clients who completed one session only would have received a significant amount of treatment, since the first session is for the most part dedicated solely to assessment.

Consequently, pre and post treatment scores could not be captured based on a single initial session. In order for clinical effect to be predicted, clients had to have completed the routine outcome measures at least twice throughout the course of their treatment. Caseness criteria also requires a client to score 10 and/or 8 or above on the PHQ-9 and GAD-7 respectively pre-treatment. Based on IAPT evaluations to date, a client is considered to have recovered if he or she was a ‘case’ at the baseline interview pre- treatment, and subsequently achieved scores below the clinical threshold at post-treatment. It should be noted that this method does not consider if the observed change is greater than the measurement error of the psychometrics. Consequently a client beginning treatment with a score just above the clinical threshold, and completing treatment just below it will be classified as ‘recovered’ irrespective of statistical reliability.

3.4.5 Analytic Plan: Reliable symptom change

To address this issue, a reliable recovery index was used in keeping with existing IAPT studies (Jacobson & Truax, 1991). Clients were considered to be ‘reliably recovered’ if they scored above the clinical threshold at assessment, showed reliable improvement during the course of treatment, and scored below clinical thresholds on both the PHQ-9 and GAD-7 on completion of treatment. Reliable improvement was determined using reliable change criteria, in keeping with existing IAPT evaluations (Gyani et al., 2013). Clients were considered to have ‘reliably improved’ if either of their measure scores reliably decreased and the score for the other measure either remained the same or did not reliably deteriorate. Specifically this required a reduction of six or more on the PHQ-9 and/or a reduction of four or more on the GAD-7 from baseline to the end of treatment. Clients were considered to have reliably deteriorated if either measure score reliably increased, or the other score either also increased or did not reliably improve. Specifically this required an increase of six or more on the PHQ-9 and/or an increase of four or more on the GAD-7 from baseline to the end of treatment. In order to achieve reliable recovery, clients must first have demonstrated reliable improvement and furthermore as previously outlined, must have had scores below the clinical thresholds on both the PHQ-9 and GAD-7 by the end of treatment. Please see figure 3.1 for details on the pathways determining casesness, reliable improvement, deterioration and recovery. A further example is outlined below:

- A case client with the following scores would have demonstrated reliable improvement: baseline PHQ-9 (13), baseline GAD-7 (9), final PHQ-9 (7), final GAD-7 (8).
- A case client with the following scores would have demonstrated reliable deterioration: baseline PHQ-9 (14), baseline GAD-7 (10), final PHQ-9 (9), final GAD-7 (14).
- A case client with the following scores would have demonstrated reliable recovery: baseline PHQ-9 (15), baseline GAD-7 (8), final PHQ-9 (8), final GAD-7 (5)

The reliable change index (Jacobson & Truax, 1991) was once again applied in order to calculate rates of reliable improvement and deterioration for depression and anxiety at the follow-up point, and to subsequently calculate rates of overall improvement, deterioration and recovery. Change scores were determined by comparing baseline and follow-up totals for the PHQ-9 and GAD-7. This reliable change criteria was further compared with the change criteria clients had or had not met by the end of treatment.

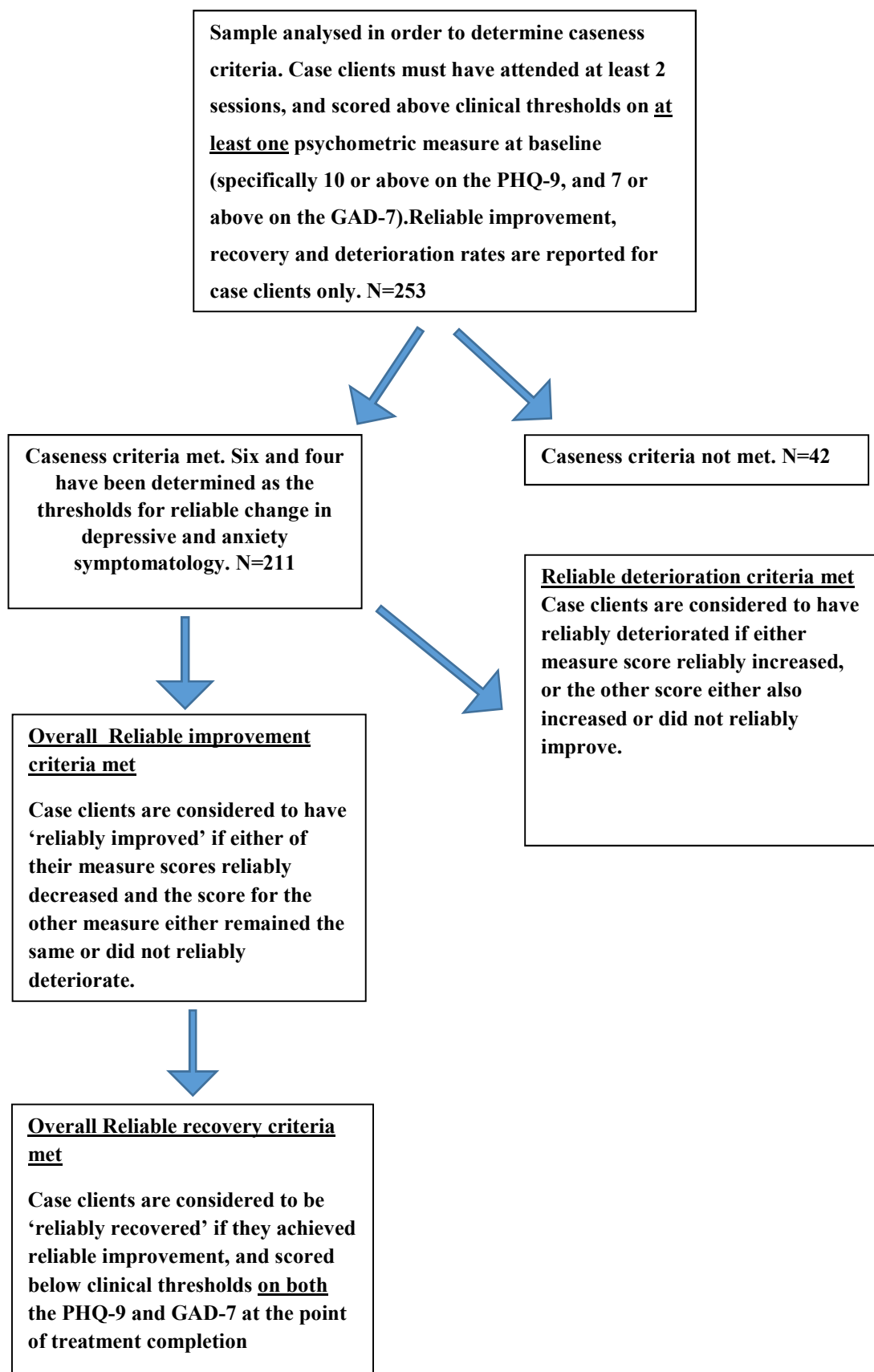


Figure 3.1: Determining caseness and reliable change criteria

3.4.6 Measures

As per IAPT service protocol, each client at each contact completed two routine outcome measures. The Patient Health Questionnaire (PHQ-9) (Appendix D), was used to measure the severity of depressive symptoms. This is a nine-item standardised measure which has been validated in a UK depressed population (Cameron, Crawford, Lawton & Reid, 2008). The scores range from 0 to 27, with a score of ten or more being the threshold to identify clinically relevant depressive symptoms (Kroneke, Spitzer & Williams, 2001).

The General Anxiety Disorder Questionnaire (GAD-7) (Appendix E), has also been determined to have good psychometric properties having been validated in U.S. populations. The scores range from 0 to 21 and a score of eight or more being the threshold to identify clinically relevant general anxiety disorder (Kroneke, Spitzer, Williams, Monahan & Lowe, 2007).

3.4.7 Interventions

Low Intensity CBT was provided by carefully trained and supervised trainee PWPs (N=29) (enrolled on MSc Applied Psychology course at Ulster University). Training followed the national BPS accredited curriculum. The specific LICBT interventions offered to each client were as described in Chapter 2. PWPs are required to adopt a collaborative and patient centred approach which involves formulating a treatment plan for each client agreed on by both client and practitioner.

3.5 Results

3.5.1 Descriptive statistics for case clients

Details regarding the nature and severity of presenting problem symptoms for the sample meeting caseness criteria, are presented in Table 3.2. More specifically this indicates the prevalence of mood, anxiety or comorbid diagnoses within the sample as determined by the trainee PWP at the point following initial clinical assessment. The particular anxiety disorders included within the anxiety diagnoses in this case are general anxiety disorder, panic disorder (with or without agoraphobia), specific phobias, health anxiety, PTSD, and OCD. The majority of case clients (46%) were reported as having comorbid difficulties (depression and anxiety) at this baseline point. The severity of symptomatology are categorised as minimal, mild, moderate, moderately severe or severe. The majority of clients presented with moderate or moderately severe symptoms at assessment for both depression (50.7% as indicated by the baseline PHQ-9 score), and anxiety (51.6% as indicated by the baseline GAD-7 score).

The outcomes of the risk assessment conducted by the trainee PWP at clinical assessment are presented in Table 3.3. It was determined that the majority of case clients demonstrated no current risk (76.8%), and furthermore that a majority of the sample provided no evidence of being previously at risk (68.7). Where some level of current or previous risk was reported at this point, it specifically referred to suicidal ideation, plans or behaviours. In relation to clients' history of mental difficulties, the specific details of diagnoses are indicated in Table 3.4. Clinical assessment outcomes reported that the majority of the case sample had a history of difficulties (71.6%)

with most of these disclosing at least one previous episode of depression (54.3%).

Information regarding treatments previously received for earlier difficulties was also gathered. It revealed that 106 clients received either medication or talking therapies before, indicating therefore that 45 clients did not access or receive any formal treatments for previous mental health issues.

Table 3.2 Details of baseline mental health difficulties within caseness sample (n=211)

	n	%
Primary Presenting Problem		
Diagnosis of mood disorder	52	24.6
Diagnosis of anxiety disorder	62	29.4
Diagnosis of comorbid mood and anxiety disorders	97	46
Baseline symptom severity (depression)		
Minimal	9	4.3
Mild	26	12.3
Moderate	46	21.8
Moderately severe	61	28.9
Severe	69	32.7
Baseline symptom severity (anxiety)		
Mild	3	1.4
Moderate	33	15.6
Moderately severe	76	36
Severe	99	46.9

Table 3.3 Outcomes of baseline risk assessments within caseness sample (n=211)

	n	%
Current risk		
No current risk	162	76.8
Some level of risk determined	49	23.2
Previous risk		
No previous risk	145	68.7
Some level of previous risk determined	65	30.8

Table 3.4 Details of previous mental health difficulties and treatment (n=211)

	n	%
Details of diagnoses for previous difficulties		
Diagnosis of mood disorder	82	38.9
Diagnosis of anxiety disorder	36	17.1
Diagnosis of comorbid mood and anxiety disorders	33	15.6
No previous history of difficulties	60	28.4
Details of previous treatment received		
Medication	10	4.7
Talking Therapy	96	45.5
None	105	50.2

3.5.2 Improvement, deterioration and recovery

The total duration of LICBT treatment for ‘case’ clients ranged between two and eleven sessions with a mean treatment duration of 6 (SD= 2.25). In relation to depression, 59.7% of clients achieved reliable improvement and reliable deterioration was determined in 2.8%. Reliable improvement and deterioration rates of 73.9% and 4.3% respectively, were determined for anxiety symptoms. Overall reliable deterioration at the point of treatment completion was observed in 5.2% of clients, and overall reliable improvement was achieved by 78.7% of clients. The criteria for overall reliable recovery was met by 52.1% of case clients. When these clinical outcomes were compared with national IAPT findings for 2017, there was no proportional difference observed in overall reliable recovery rates between clients treated in Northern Ireland and those treated in England at the same time period [$\chi^2(1, N = 211) = 1.79, p > 0.1$]. However, the proportion of clients treated in Northern Ireland who demonstrated overall reliable improvement was significantly higher when compared with rates in England, [$\chi^2(1, N = 211) = 15.21, p < 0.001$].

3.5.3 Reliable change at follow up

Table 3.6 presents the rates of achieved reliable symptom change criteria for case clients with complete data at the treatment end point, and at the four month follow up point. Rates of overall reliable improvement at the end of treatment and at follow-up were identical (86.7%). Moreover, the majority of clients demonstrated overall reliable recovery at both treatment end (57.8%), and at follow-up (73.3%). The changes achieved at both time points are further compared in Table 3.7; more

specifically this indicates the number of clients who either maintained or lost treatment gains.

Of 26 clients who achieved overall recovery at treatment end, 24 still met this recovery criteria at the follow-up point. Furthermore, 9 clients who had not achieved recovery criteria by the end of treatment subsequently met the criteria at the four month follow-up.

Table 3.5: Frequencies and percentages of reliable recovery, improvement and deterioration rates for all case clients meeting (n= 211).

	Reliable Improvement		Reliable Deterioration		Overall Reliable Improvement	Overall Reliable Deterioration	Overall Reliable Recovery
	(PHQ-9)	(GAD-7)	(PHQ-9)	(GAD-7)			
Yes	126 (59.7%)	156 (73.9%)	6 (2.8%)	9 (4.3%)	166 (78.7%)	11 (5.2%)	110 (52.1%)
No	85 (40.3%)	55 (26.1%)	205 (97.2%)	202 (95.7%)	45 (21.3%)	200 (94.8%)	101 (47.9%)

Notes: *At least 2 sessions attended and above clinical thresholds on one or both measures at baseline = caseness .

Table 3.6: Frequencies and percentages of reliable change for case clients with completed follow-up, at discharge and four months post discharge (n= 45).

		Reliable Improvement		Reliable Deterioration		Overall Reliable Improvement	Overall Reliable Deterioration	Overall Reliable Recovery
		(PHQ-9)	(GAD-7)	(PHQ-9)	(GAD-7)			
Yes	Discharge	30 (66.7%)	39 (86.7%)	2 (4.4%)	1 (2.2%)	39 (86.7%)	1 (2.2%)	26 (57.8%)
	Follow-up	30 (66.7%)	38 (84.4%)	1 (2.2%)	1 (2.2%)	39 (86.7%)	1 (2.2%)	33 (73.3%)
No	Discharge	15 (33.3%)	6 (13.3%)	43 (95.6%)	44 (97.8%)	6 (13.3%)	44 (97.8%)	19 (42.2%)
	Follow-up	15 (33.3%)	7 (15.6%)	44 (97.8%)	44 (97.8%)	6 (13.3%)	44 (97.8%)	12 (46.7%)

Notes: *At least 2 sessions attended and above clinical thresholds on one or both measures at baseline = case client

Table 3.7: Frequencies and percentages of reliable symptom changes maintained between discharge and four month follow-up (n=45)

	Reliable Improvement		Reliable Deterioration		Overall Reliable Improvement	Overall Reliable Deterioration	Overall Reliable Recovery
	(PHQ-9)	(GAD-7)	(PHQ-9)	(GAD-7)			
Not achieved at discharge or follow-up	10 (22.2%)	4 (8.9%)	43 (95.6%)	44 (97.8%)	3 (6.7%)	44 (97.8%)	10 (22.2%)
Achieved at discharge, not maintained at follow-up	5 (11.1%)	3 (6.7%)	1 (0.4%)	0 (0%)	3 (6.7%)	0 (0%)	2 (0.8%)
Not achieved at discharge but achieved at follow-up	5 (11.1%)	2 (4.4%)	0 (0%)	0 (0%)	3 (6.7%)	0 (0%)	9 (3.6%)
Achieved at discharge and maintained at follow-up	25 (55.6%)	36 (80.0%)	1 (0.4%)	1 (0.4%)	36 (14.2%)	1 (0.4%)	24 (53.3%)

3.6 Discussion

3.6.1 Clinical features of case clients

Although 32.7% and 46.9% of the case client sample were determined to have severe baseline symptoms for depression and anxiety respectively, it does not automatically indicate unsuitability for a low intensity intervention. Evidence from a meta-analysis found that those with more severe baseline depression symptoms were equally as likely to achieve treatment gains as those with less severe symptoms suggesting that clients with severe symptoms could still be usefully provided with low intensity care within a stepped care model (Bower et al., 2013). The suitability of the case client cohort is further evidenced by the low rates of risk determined at baseline (23.2%). LICBT within IAPT services is not recommended for those demonstrating significant suicide risk; this refers to suicidal intent or behaviour and not necessarily suicidal ideation (Clark et al., 2009). Given that case clients in the current study were required to attend at least 2 sessions with the PWP, it may be concluded (as per the model within which the PWPs were working), that those demonstrating significant suicide risk were stepped up and that non-case clients at significant risk were stepped up immediately following assessment. Regarding the recurrent nature of difficulties within the sample, 71.6% were found to have experienced at least one previous episode of mental health difficulties prior to the onset of their current difficulties which indicates that a large number of client's current difficulties may have been enduring and/or complex, potentially affecting suitability for LICBT. This was not unexpected however, given that recurrences of depression and anxiety do occur frequently.

More specifically, the risk of recurrence within 15 years for depression is 35% and recurrence rates for anxiety range from 39% to 58% depending on the particular anxiety disorder (Bruce et al., 2005; Hardeveld et al., 2013). It must be acknowledged in the current evaluation, that trainee PWPs may not always have accessed confirmation of official previous diagnoses, particularly where there was no previous contact with healthcare services. In some cases therefore, the information regarding previous episodes was a result of client disclosure. Regardless of the information source however, it must be noted that diagnostic instability can result in misleading information pertaining to recurrence (Scholten et al., 2016).

3.6.2 Initial Northern Ireland outcomes: Clinical effectiveness

Findings from the current study are in keeping with outcomes from UK IAPT sites. More specifically, when NI reliable change rates are compared directly with published IAPT UK outcomes for 2016/17 (HSc, 2017), reliable recovery rates are 52.1% and 47% respectively. Reliable improvement rates are 78.7% and 65.1% for NI and England respectively (HSC, 2017). These preliminary results provide initial evidence that low intensity cognitive behavioural therapy can be an effective treatment for mild to moderate level mental health difficulties in NI.

Moreover, the findings derived from analysis of follow up data, indicate that 55.6% and 80% of reliable symptom improvement gains for depression and anxiety respectively, were maintained at a point four months post treatment. The finding that reliable improvement was maintained for a higher proportion of patients on the GAD-7 compared with the PHQ-9, is in keeping with reports from previous studies that depression tends to have a higher recurrence rate than anxiety (Burcusa & Iacono, 2007).

Overall reliable improvement was maintained in 79.9% of cases and overall reliable recovery in 53.3% of cases. Whilst these outcomes are favourable when compared with another recent longitudinal LICBT evaluation (Ali et al., 2017), it must be acknowledged that the duration between the treatment end point and the follow up point was shorter in the current study (4 months as opposed to 12 months), and the sample of patients for which follow ups were completed was significantly smaller (45 as opposed to 439). However, in regards to the larger evaluation it was reported that 80% of relapses occurred within the first six months (Ali et al., 2017), and therefore the promising outcomes determined from analysis of follow up data in the current study should be recognised.

IAPT outcomes consistently report higher improvement rates compared to recovery rates, given that improvement considers only the scale of change, and not whether the client has moved below clinical caseness. It is important to acknowledge that the service evaluated in the current report is not an official IAPT service, and trainee PWP's were not working under the usual high volume caseload.

This may partly account for the higher improvement rates presented for Northern Ireland; the sample in the current evaluation is considerably smaller than numbers treated by IAPT services in England. Furthermore, the overall outcomes reported by UK IAPT services, consider those who may have been treated by both low and high intensity therapies throughout the course of treatment. Importantly, reports on the use of IAPT services highlight the fact that a patient's therapy type can change between appointments. Therefore, two or more therapy types may be used within a single referral, meaning a client may have received both low and high intensity interventions.

Although the current report includes the outcomes of those who were stepped up to higher intensity care, only low intensity interventions were delivered and evaluated. Consequently, a higher proportion of suitable referrals within the Northern Ireland sample, may partly account for the higher improvement rates reported here.

As reported earlier the prevalence of mental difficulties in NI is 25% higher than in England (DHSSPS, 2014). More explicitly, the Northern Ireland Health Survey (2014/15) reported that 19% of respondents exhibited symptoms of a potential mental health problem (Bell & Scarlett, 2015). It would be reasonable to assume that at least some of this population would be suitable for low intensity interventions, and that an established PWP service in Northern Ireland may contribute to reducing the prevalence of difficulties by improving access to psychological therapies at the primary care level, as the IAPT initiative has done in England. (Layard & Clark, 2015).

It is also important to acknowledge that LICBT interventions in the current study were delivered by trainee PWPs. Recent research has indicated clients treated by qualified PWPs had superior clinical outcomes when compared with trainee PWPs, although further research investigating relationships between therapist experience and competence, and patient outcomes is needed, particularly in relation to low intensity interventions (Branson, Myles, Mahdi & Shafran, 2017).

3.6.3 Limitations

The absence of a control group is an acknowledged limitation of the current study, however it is proposed that this will be included in future evaluations

3.6.4 Future Research

In order to analyse the clinical effectiveness of this approach further, Chapter 4 will investigate the individual level variables which may impact treatment outcomes and treatment response trajectories. More specifically, it will aim to identify the client characteristics which are predictive of improvement, recovery or deterioration in relation to depression and anxiety symptoms. Such information is useful in order to inform future clinical practice and service development; for whom does LICBT work best?

3.6.5 Chapter Conclusion

Currently, the mental health service framework in NI does not formally apply this NICE evidence, which has also been highlighted in the recent *Evaluation of the Bamford Action Plans* (DH, 2016). The preliminary findings presented in the current chapter indicate that reliable recovery and improvement have been demonstrated for clients in NI who have presented with common mental health difficulties. Indeed, LI-CBT interventions (provided by PWP's) provides the only evidence base to date in NI for treating anxiety and depression at stepped care levels 1-3. Additionally, the Bamford evaluation highlighted a need to further promote psychological therapies, to improve access to services in times of crisis, and to improve involvement at the community and voluntary level (DH, 2016; Betts & Thompson, 2017). Initial findings indicate that PWP's have addressed this need.

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Chapter 4

Modelling changes in anxiety and depression during LICBT: An application of growth mixture models.

Chapter overview

Chapter 3 has presented preliminary evidence for the effectiveness of the PWP service model in NI, and more specifically indicated that rates of reliable symptom change are comparable with National IAPT outcomes for patients with mild to moderate level depression and anxiety. Knowledge regarding the predictors of treatment response, however, is relatively limited. The primary aim of the current chapters was to model the heterogeneity in longitudinal changes in anxiety and depression throughout LICBT provided by PWPs in Northern Ireland (NI), and to explore associations between pre-treatment variables and differences in treatment response. Growth mixture modelling (GMM) techniques were employed to examine changes in psychological status in clients (N=253) over the first six sessions of treatment in order to identify divergent early response trajectories. A series of pre-treatment variables were used to predict class membership using Chi-Square tests and binary logistic regression models.

4.1 Introduction

There is strong evidence that psychological therapies are effective (Weston, Novotny & Thompson-Brenner, 2004). However, efficacy is frequently determined by analyses of the mean level of change for the entire sample. Although the majority of patients may improve throughout a course of therapy, some benefit more than others and some can deteriorate. Moreover, some patients achieve significant gains at an early point in treatment and some take longer to achieve change (Lilienfeld, 2007; Heppner, Kivlighan & Wampold, 2008). Identifying response patterns which differ from expected trajectories is important in order to understand the psychological processes which underpin successful and unsuccessful interventions (Bauer, 2011; Frankfurt, Frazier, Syed & Jung, 2016); increasing knowledge about individual differences in patterns of change for specific sub-groups of patients, can help researchers and practitioners to maximise treatment outcomes for individual patients (Barlow, 2010; Lambert, 2007; Lutz, 2002).

Examinations of change often focus on pre to post treatment comparisons, which assume that patients with a positive treatment outcome have also followed a positive response pattern, and that a negative response pattern is typical for those with overall negative treatment outcomes. Consequently, groups achieving defined outcome criteria (e.g. reliable recovery) are grouped together even though the course of treatment response potentially varies significantly (Morrall, Iguchi, Belding & Lamb, 1997). The probable diversity within pathways to improvements may be both clinically meaningful and an important predictor of outcome.

As indicated in the previous chapters, several studies and reviews have contributed to a robust evidence base for the effectiveness of CBT self-help materials in the treatment of depression and anxiety. Gellatly et al. (2007) conducted a meta-analysis on self-help and depression from which a large effect size was reported following guided self-help. Additional reviews have found evidence supporting the use of guided self-help with a cognitive behavioural framework in the treatment of anxiety disorders (Lewis, Pearce & Bisson, 2012; Landreville, Gosselin, Grenier, Hodson & Lorrain, 2016).

Similarly, Coull and Morris (2011) found guided self-help to be effective in the treatment of both depression and anxiety disorders, with a greater effect with clients who had self-referred. As discussed earlier, evaluations to date also support the IAPT service model, and specifically indicate that LICBT is effective for mild to moderate difficulties (Clark et al., 2009; Gyani et al., 2013). Preliminary evaluations of the PWP service in Northern Ireland (NI) as displayed in Chapter 3, have determined deterioration rates of 6.1%, recovery rates of 47.9%, and improvement rates of 76.7%. The proportion of clients treated in Northern Ireland who demonstrated overall reliable improvement was significantly higher when compared with rates in England during the same time period, although no proportional difference was observed in relation to recovery (HSc 2016; McDevitt-Petrovic et al., 2018).

4.1.1 What works for whom and when?

Early treatment response patterns have been shown to be associated with outcomes across different disorders (Bradford et al., 2011; Lewis, Simons & Kim, 2012); different treatment modalities (Crits-Christoph, 2001; Gunlicks-Stoessel & Mufson, 2011), and different psychometric measures (Hunter, Muthen, Cook & Leuchter, 2009)

Although a large evidence base exists supporting the effectiveness of CBT, a considerable number of individuals do not benefit from treatment, and drop out or relapse (Loerinc et al., 2015), and no reliable predictors regarding who is likely to benefit have been determined (Porter & Chambless, 2015; Schneider, Arch & Wolitzky-Taylor, 2015). It is important to acknowledge therefore that an empirically based intervention which has been deemed efficacious and effective, may not always be the optimal treatment option for all patients (Howard, Moras, Brill, Martinovich & Lutz, 1996).

‘Treatment responder’ is the term often used to refer to patients who have achieved significant gains from treatment. From a clinical perspective knowledge about response classifications can inform practitioners if interventions need to be modified or even discontinued. In research settings, the proportion of responders represents an index of efficacy. The ability to categorise patients as either likely responders or likely non-responders is important in relation to individualised care plans.

Therapists by themselves are often unable to correctly identify patients who are failing to adequately progress or who are likely to drop out treatment before adequate change is achieved (Hatfield, McCullough, Frantz & Krieger, 2010). These patients have been referred to as ‘Not on Tracks’ (NOT; Lambert et al., 2003).

A frequent focus of recent research has been on investigating symptom change patterns in order to reliably distinguish these from patients who are on track. More specifically, much research has focused on early treatment response and change patterns, as this is considered to an important phase of therapy in relation to predicting overall positive outcomes (Fluckiger, Del Re, Wampold, Symonds & Hovarth, 2012).

4.1.2 Predictors of treatment outcome

Sociodemographic variables have been widely investigated as predictors of non-response and treatment drop-out, yet they have been determined as either inconsistent or non-significant (Clarkin & Levy, 2004; Taylor, Abramovitz & McKay, 2012). There remains an important need to identify predictors of treatment outcome in order that resources may be allocated to those presumed to be likely to achieve improvement or recovery, while similarly identifying those who may deteriorate and require alternative or higher intensity care (Neilsen et al., 2017).

In relation to baseline predictors of outcome after CBT for depression, more favourable treatment outcomes are frequently found among patients with lower symptom severity (Hamilton & Dobson, 2002; Coffman, Martell, Dimidjian, Gallop, & Hollon, 2007), shorter duration of current episode of difficulty, fewer number of previous episodes (Hamilton & Dobson, 2002), and absence of comorbidity (Gelhart & King, 2001; Driessen & Hollon, 2010).

Predictors of treatment response to CBT for anxiety include initial severity of symptoms (Kampman, Keijers, Hoogdion & Hendricks, 2008), interpersonal problems (Borkovec, Newman, Pincus & Lytle, 2002), patient expectations of positive outcomes (Price & Anderson, 2012), homework completion (Schmidt & Woolaway, Bickel, 2000), therapist competency, and fidelity to treatment modality (Kazantzis, 2003).

Gyani et al. (2013) investigated patient level characteristics from year one of IAPT for those who received both low and high intensity interventions. Recovery was more likely to be achieved by those with lower initial symptom severity, by those with a baseline diagnosis of depression or general anxiety disorder, and by those who were not receiving other concurrent treatments. It has been reported that baseline moderate distress is most likely to result in significant improvement, with this likelihood reduced for patients with either high or low levels of initial distress. For those with initial low levels, the reduced improvement may be due in part to reduced opportunities for change. Improved treatment outcomes following high levels of initial symptomatic distress are possibly explained by higher motivations and increased opportunities for change. Reviews to date have also suggested briefer episode duration is associated with more positive treatment outcomes and that those with recurrent difficulties are less responsive regardless of treatment modalities and combinations (Hamilton and Dobson, 2002). Recent research has also found that unemployment, and the use of antidepressants were associated with poorer response to LICBT (Knapstad, Nordgreen & Smith, 2018); it may be suggested that these are indirect markers of more enduring difficulties.

4.1.3 Examining change using growth mixture modelling

Most studies that have examined the efficacy of low intensity interventions have relied on the categorical model of outcome, described as either reliable improvement, deterioration or recovery (Jacobson & Truax, 1991). However, some studies have focused on describing the longitudinal change in outcome variables during low intensity interventions. The use of growth mixture models (GMM) allows different homogeneous groups, or classes, to be found that share similar characteristics of change in terms of their initial level (intercept) and nature and rate of change (slope).

A recent study (Rubel et al., 2015) has compared the concept of clinically significant change (Jacobson & Trux, 1991) with a GMM method relating to their shared and distinct characteristics for the identification of positive early treatment response. Although both methods have been used to identify early change patterns and help practitioners evaluate patient progress as well as the need to potentially modify treatment plans (Lutz, Bohnke, Kock, 2011), it has not yet been established if GMM-identified early responders are a more informative sub-group than those determined with less complex change evaluations (e.g. reliable change). The GMM approach identified a highly specific subgroup of early improving patients who were also characterized by higher average baseline impairments and higher pre- to-posttreatment score differences. Although it was more specific for the prediction of positive treatment outcome, GMM was substantially less sensitive than clinically significant and reliable change criteria. Consequently, those who improved reliably or clinically significantly from pre to post treatment would have been missed if only GMM was used.

There were no differences between the groups in relation to the duration of treatment. Given that each of the approaches revealed specific advantages, results recommend a combination of both methods for practical use in routine outcome monitoring and treatment planning.

4.1.4 Key findings from recent studies using GMM

Lutz et al. (2009) used GMM to identify typical patterns of early change over 8 weeks within a sample of patients with major depression. The three patterns which emerged included those with moderate depression and early improvement, those with moderate to severe depression and rapid early improvement, and those with mild to moderate depression and early improvement. These predicted the outcome of symptom severity at the end of treatment and at 18 months follow-up. Similarly, Thibodeau et al (2015) used GMM in order to identify patient sub-groups with distinct symptom trajectories following a course of psychotherapy and antidepressants. Four distinct latent growth classes were determined. One class included gradual responders with high symptom severity accounting for 42% of the sample. The remaining classes represented gradual responders with moderate symptom severity (31%), non-responders (15%), and rapid responders (11%). Several factors were predictive of non-response, namely initial severity, high levels of emotional coping, less avoidant behaviour, introversion, and reduced emotional stability. Growth trajectories were independent of treatment modality and classes were not associated with dropout rates.

Lutz et al. (2014) also used GMM to determine latent classes of early change in patients undergoing CBT for panic disorder. Results again suggested that early treatment changes are uniquely predictive of treatment outcome. More specifically 4 latent subgroups were identified, with clusters of change trajectories over the first five sessions of treatment. One subgroup included patients with rapidly decreasing symptoms and subsequently the best outcomes. This information improved prediction of treatment outcome by 16.1% more than patient baseline characteristics, and significantly predicted early drop-out.

Smits et al. (2016) also investigated early symptom change trajectories in adult outpatients undergoing psychotherapy. More specifically the study aimed to examine patient characteristics predictive of trajectory classes and to further examine the moderating effect of class membership on the therapeutic alliance. Four clinically relevant sub-groups were identified in relation to early symptom change patterns (high distress with no change, low distress with moderate improvement, moderate/low distress with small improvement, and moderate low distress with strong improvement). Class membership was predicted by baseline psychological distress and emotional dysregulation, Class membership was not associated with the development of early therapeutic alliance.

Other research has considered the impact of later phases of treatment. Rubel, Lutz and Schulte (2015), used GMM to determine latent change classes in different phases of treatment for outpatients attending psychotherapy. In addition, the study investigated the relationship between the change patterns in different phases and their predictive power regarding treatment length and outcomes.

Five change patterns were determined on an early treatment phase (1-6 sessions), three in the second (7-12 sessions), and two in the third (13-18 sessions). In summary, the majority of change in patient progress occurred during the early phase of treatment and subsequently levelled out. Although significant improvements were evident during later treatment phases, they occurred less frequently compared with earlier phases.

Some GMM research has focused on response patterns during *low intensity* interventions. Delgadillo, McMillan, Lucock, Leach, Ali and Gilbody (2013) examined data from patients who had attended IAPT Improving access to psychological therapies (IAPT) services in England. This intervention ranged from 1 to 8 sessions and included telephone sessions. Early response was defined as having achieved reliable improvement by session 4 and was predictive of clinically significant (reliable) recovery by the end of treatment. It was reported that attrition was highest in earlier sessions, thereby highlighting that early attempts to engage patients should be made. More recently, Lutz et al (2017) examined changes in depression between initial screening and the fourth week of therapy for 409 participants enrolled on a web-delivered CBT intervention. They reported that the GMM indicated three distinct and homogenous groups: Early response after registration, early response after screening, and early deterioration. Similarly, Lutz et al (2014) used GMM to identify different patterns of change in patients with panic disorder (N = 326) who took part in a manualized cognitive-behavioral treatment. During the first five treatment sessions the sample data was best described by four classes (early deterioration, medium symptoms – slow change, high symptoms – no change, early response).

It has been argued that such analysis provide better predictions about longterm treatment outcome and can facilitate the identification of variables that predict treatment success.

4.1.5 Aims

The primary aim of this study was to model the longitudinal changes in depression and anxiety during the first six sessions of low intensity cognitive behavioural therapy provided by PWPs in Northern Ireland using GMM techniques. Previous findings, based on a subsample of the participants from this study, showed that 59.5% and 70.6% of clients achieved reliable improvement in depression and anxiety respectively, so there is clearly heterogeneity in treatment response. It was predicted, for both depression and anxiety, that (1) there would be at least one class representing improvement, (2) one or more classes representing no change or deterioration, (3) improvement would be associated with higher baseline levels of depression and anxiety (Gyani, et al, 2013, Lutz et al, 2014), and (4) class membership would predict outcome. A more exploratory aspect of the study involved estimating the association between pre-treatment variables and class membership.

4.2 Method

4.2.1 Design

This study had a longitudinal design, and used pre-post interventional trial methods, following clients (N=253) from baseline (before commencement of therapy), through the course of low intensity treatment (1-11) sessions, and at discharge (final session of treatment). Low intensity in this case refers to forms of CBT guided self-help which require less practitioner support in terms of the frequency and duration of sessions (Richards & Whyte, 2011). PWP best practice guides report the average number of contacts to be around 5 sessions, compared with a high intensity average of around 12 (UCL, 2014). The duration of LICBT in the current study ranged between 1 and 11 sessions and the mean number of sessions was 5.55 (SD= 2.61). Recent IAPT evaluations have also indicated that maximum treatment benefits tend to plateau after six sessions (Delgadillo et al., 2014; Firth, Barkham, Kellett & Saxon., 2015). The current study therefore specifically examined changes in psychological status in clients over the first six sessions of treatment in order to identify divergent early response trajectories and subsequently predictors of improvement.

4.2.2 Participants and treatment

A total of 253 patients were referred to and treated by one of 29 trainee PWPs in NI between January 2015 and November 2017. There were 152 (60.07%) female patients and 101 (39.93%) were male. Ages ranged between 18 and 77 with a mean age of 38 years (SD=13.5).

Additional information collected and used for research purposes at the pre-treatment point included the following: marital status, employment status, diagnosis (mood, anxiety, or mixed), use of medication, use of alcohol and drugs, current and previous risk of harm and/or neglect to self and others, details of previous difficulties, details of previous treatments, details of concurrent treatments, and onset of current difficulties.

A total of 12 services facilitated treatment including 2 GP practices, 3 NHS trust sites and 7 community organisations. The low intensity clinical procedures implemented by PWP's included behavioural activation, cognitive restructuring, exposure therapy, problem solving, managing panic, sleep hygiene, and medication support. Although this is not an exhaustive list of interventions, it does represent the core clinical procedures that PWP's employ (Richards & Whyte, 2011). In keeping with the stepped care framework (Scogin, Hanson & Welsh, 2003), the systematic monitoring of client's therapeutic progress by the trainee PWPs and their clinical supervisors ensured clients were stepped up to a higher intensity service where it was deemed to be clinically required i.e. where there had been an inadequate response to low intensity treatments (Seekles, van Straten, Beekman, Marwijk & Cuijpers, 2011).

4.2.3 Measures

As per IAPT protocol, each client completed two routine outcome measures at every session. The total psychometric scores at each session were used to assess depression and anxiety symptom severity, and to estimate latent growth classes for each. Symptomatic change was also calculated using a reliable change index (Jacobson & Truax, 1991), and more specifically indicated if each patient achieved overall deterioration, improvement and/or recovery criteria by the end of treatment.

Depression: The PHQ-9 (Kroenke, Spitzer & Williams, 2001) was used to assess symptoms of depression. The PHQ-9 is a 9-item self-report measure scored on a 4-point Likert scale ('Not at all' (0) to 'nearly every day' (3)). Higher scores indicate higher severity of depressive symptomatology, and total scores range from 0 to 27. The internal reliability of the scale in prior studies is excellent ($\alpha = .89$, Kroenke, Spitzer & Williams, 2001) and maintained in the current study at baseline ($\alpha = .84$).

Anxiety: The GAD-7 (Spitzer, Kroenke & Williams, 2006) was used to assess symptoms of generalized anxiety. The GAD-7 is a 7-item self-report measure scored the same way as the PHQ-9. Higher total scores indicate higher severity of anxiety, and total scores on the GAD-7 range from 0 to 21. Scores greater than or equal to 8 are indicative of clinically relevant level of anxiety (ref). Internal reliability of the scale in prior studies is excellent ($\alpha = .92$, Spitzer, Kroenke & Williams, 2006) and maintained in the current study at baseline ($\alpha = .81$).

4.2.4 Pre-treatment variables

A series of pre-treatment variables were used to predict class membership as described below:

Gender: A binary variable indicating male or female.

Employment: A variable to determine baseline employment status identified clients as either in employment or full time study, unemployed, retired, or on sick leave. This was subsequently collapsed into a binary variable which identified clients as either employed/fulltime study, with all others categorised as unemployed (0 = employed, 1= unemployed).

Suicide risk: This variable was measured subjectively as per the baseline risk assessment. The variable originally included four categories, (no current risk, suicidal ideation, suicidal intent/plans, suicidal behaviour) This was subsequently collapsed into a binary variable which identified clients as demonstrating no risk or as demonstrating some level of risk according to the assessing practitioner (0 = no risk, 1= some risk identified).

Medication use: The name(s) of medication(s) used by clients at baseline were recorded and categorised as none, antidepressants, antianxiety, or combinations. A binary variable was then created which identified clients as either using medication or not (0 = not using medication, 1 = using medication).

Onset of current difficulties: This was originally a continuous variable which reported a duration of difficulties ranging from one month to 50 years. This was subsequently collapsed into a categorical binary variable which identified onset as either within or longer than five years (0 = onset within the last years, 1= onset more than 5 years ago).

Neglect (of self or others): This variable was measured subjectively as per the baseline risk assessment. The variable originally included four categories (no neglect, self-neglect, neglect of others, neglect of self and others). This was subsequently collapsed into a binary variable which identified clients as demonstrating no neglect or as demonstrating some level of neglect according to the assessing practitioner (0 = no neglect, 1= some neglect determined).

Previous treatments: This variable originally consisted of multiple categories identifying previous treatments for mental health difficulties received by clients. These included, medications, generic counselling, CBT interventions, support group, psychiatric care, or combinations of these. This was subsequently collapsed into a binary variable indicating if any previous treatments were received or not (0 = no previous treatments, 1= previous treatments)

Concurrent treatments: This variable originally consisted of multiple categories identifying treatments apart from medications being provided concurrently to clients alongside LICBT. These included generic counselling, eating disorders clinic, occupational therapy, learning disability service, adult autism service, mindfulness classes, support groups and exercise programmes. This was subsequently collapsed into a binary variable indicating if any concurrent treatments were being provided or not (0 = no concurrent treatments, 1= concurrent treatments).

Comorbidity: This variable originally contained information describing the presenting problem of clients at baseline, and included depression, generalised anxiety, social anxiety, health anxiety, panic disorder (with or without agoraphobia), specific phobia, OCD, PTSD, chronic physical pain, or a combinations of these. This was subsequently collapsed into a binary variable indicating if clients presented with

depression or anxiety only at baseline, or presented with both (0 = no comorbidity, 1 = comorbidity).

4.2.5 Analytic Plan

The first phase of analysis used growth mixture modelling (GMM: Muthén & Shedden, 1999; Muthén & Muthén, 2000) to identify different change trajectories of individual's levels of depression and anxiety. The baseline models were a latent growth models (LGM) with six observed variables representing the repeated measurements of anxiety and depression. The loadings on the intercept latent variable were fixed at 1, so the mean of the latent variable represented the average anxiety/depression score at time 1. The loading for the slope latent variable were fixed at 0, 1, 2, 3, 4, 5 to represent linear change over time. For the GMM successive classes were added allowing the mean and variance of the intercept and slope latent variables to vary across classes. Models with 1 through to 4 classes were estimated. The model parameters were estimated using robust maximum likelihood estimation (MLR) and this handled the missing data by using all available information.

The relative fit of the models was compared by using three information theory based fit statistics: The Akaike Information Criterion (AIC; Akaike, 1987), the Bayesian Information Criterion (BIC; Schwartz, 1978) and the sample size adjusted Bayesian Information Criterion (ssaBIC; Sclove, 1987). The class solution that produced the lowest value can be judged the best model. Evidence from simulation studies have indicated that the BIC was the best information criterion for identifying the correct number of classes (Nylund et al., 2007). A 6- to 10-point difference between two models indicates strong evidence that the model with the lower value is statistically superior (Raftery, 1995).

In addition, the Lo-Mendell-Rubin adjusted likelihood ratio test (LMR-A; Lo et al., 2001) was used to compare models with increasing numbers of latent classes. When a non-significant value ($p > .05$) occurs, this suggests that the model with one less class should be accepted. These analyses were conducted using Mplus 7.11 (Muthén & Muthén, 2013).

In the second phase of analysis the association between class membership and pre-treatment predictors was assessed using chi-square tests. The third phase of the analysis used logistic regression to assess the relationship between pre-treatment variables and class membership.

4.3 Results

Descriptive statistics for depression (PHQ-9) and anxiety (GAD-7) across the first six LICBT sessions are presented in Table 4.1. Initial assessment sessions were completed for 250 patients, after which baseline mean scores of 14.27 and 15.19 were determined for anxiety and depression respectively. A total of 231 (91.70%) patients reported scores above clinical thresholds for anxiety at baseline, and a total of 195 (77.40%) reported clinically relevant symptoms for depression. The number of patients who scored above clinical thresholds for both anxiety and depression was 189 (81.80%). The total number of patients who attended at least a second session and therefore commenced LICBT treatment was 213. Following a sixth treatment session, mean scores were reduced to 7.62 for depression, and reduced to 7.13 for anxiety. Anxiety scores at session 6 were recorded for 138 patients of which 87 (63.0%) scored below clinical thresholds. Depression scores at session 6 were recorded for 141 patients, of which 96 (68.10%) scored below clinical thresholds. Of the 138 patients for whom both anxiety and depression scores were recorded at session 6, a total of 83 (60.14%) scored below the clinical thresholds on measures.

Table 4.1: Descriptive statistics for depression (PHQ-9) and anxiety (GAD-7) across the first six LICBT sessions.

Outcome measures	Treatment Session Number					
	1	2	3	4	5	6
GAD-7 total	14.27 (4.77)	12.02 (5.46)	10.56 (5.53)	9.27 (5.61)	7.85 (4.96)	7.13 (5.36)
Mean (SD)	N= 250	N= 213	N= 200	N= 181	N=162	N=138
PHQ-9 total	15.19 (6.38)	12.85 (6.46)	11.22 (6.64)	10.01 (6.98)	8.31 (6.09)	7.62 (6.46)
Mean (SD)	N=250	N=213	N=201	N= 183	N=164	N= 141

The fit statistics for the GMM for anxiety scores (GAD-7) across the first six LICBT sessions are reported in Table 4.2. The LRT becomes non-significant for the 4-class solution which indicates that the 3-class solution should be preferred. However, the difference in the BIC for the 3 and 4-class solutions is very small, and the BIC is lowest for the 2-class solution. The entropy for the 2-class solution is also higher than the 3-class solution, so the 2-class solution is considered the best solution.

Table 4.2: Fit statistics for the GMM for anxiety scores (GAD-7) across the first six LICBT sessions.

Classes	Loglikelihood	AIC	BIC	ssaBIC	LRT	Entropy	BLRT
					P		P
1	-3234.815	6491.629	6530.365	6495.495			
2	-3223.338	6474.777	6524.077	6479.696	21.551	0.695	22.852
					.005*		.004*
3	-3215.311	6464.622	6524.486	6470.595	15.236	0.608	16.155
					.039*		.031*
4	-3211.709	6463.419	6533.848	6470.446	6.793	0.586	7.203
					.577		.561

The parameter estimates for Class 1 presented in Table 4.3, show that the estimated group GAD-7 mean was 13.22 at baseline, above the cut-off score for GAD-7, and decreased 1.78 points between each session (slope mean). The estimated mean score at time 6 was 4.32, below the cut-off score for clinically relevant symptoms. Based on most likely class membership this class comprised 207 (82.80%) of the participants and was labelled the anxiety “Improver” class. For class 2 the estimated group GAD-7 mean was 16.318 at baseline, above the cut-off score for clinically relevant symptoms, and the slope mean was not statistically significant indicating no change. Based on most likely class membership this class comprised 43 (17.20%) of the participants and was labelled the anxiety “Non-Improvers” class.

Table 4.3. Parameter Estimates for GMM model for anxiety.

	Parameter	Coefficient	Standard Error
Class 1 (35%)	Intercept Mean	13.228*	0.404
Improvers	Intercept Variance	16.651	1.836
	Slope Mean	-1.781	0.087
	Slope Variance	0.583	0.109
	Intercept - Slope	-0.737	0.057
	Correlation		
Class 2 (65%)	Intercept Mean	16.318*	0.542
Non Improvers	Intercept Variance	16.651	1.836
	Slope Mean	-0.238	0.207
	Slope Variance	0.583	0.109
	Intercept - Slope	-0.737	0.057
	Correlation		

Note: *indicates significant coefficients

The fit statistics for the GMM for depression scores (PHQ-9) across the first six LICBT sessions are reported in Table 4.4. The LRT becomes non-significant for the 4-class solution which indicates that the 3-class solution should be preferred.

However, the difference in the BIC for the 3 and 4-class solutions is very small, and the BIC is lowest for the 2-class solution. The entropy for the 2-class solution is also higher than the 3-class solution, so the 2-class solution is considered the best solution.

Table 4.4: Fit statistics for the GMM for depression scores (PHQ-9) across the first six LICBT sessions.

Classes	Loglikelihood	AIC	BIC	ssaBIC	LRT	Entropy	BLRT
					P		P
1	-3380.572	6783.143	6821.923	6787.052			
2	-3363.692	6755.385	6804.741	6760.360	31.838	0.781	33.758
					.209		.195
3	-3352.918	6739.836	6799.769	6745.877	20.323	0.692	21.549
					.006*		.005*
4	-3345.065	6730.131	6800.640	6737.237	14.812	0.650	15.705
					.186		.169

The parameter estimates for Class 1 presented in Table 4.5, show that the estimated group PHQ-9 mean was 13.88 at baseline, above the cut-off score for PHQ-9 , and decreased 1.78 points between each session (slope mean). The estimated mean score at time 6 was 4.98, below the cut-off score for clinically relevant symptoms. Based on most likely class membership this class comprised 212 (87.25%) of the participants and was labelled the depression “Improver” class. For class 2 the estimated group PHQ-9 mean was 19.151 at baseline, above the cut-off score for clinically relevant symptoms, and the slope mean was not statistically significant indicating no change. Based on most likely class membership this class comprised 38 (12.75%) of the participants and was labelled the depression “Non-Improver” class.

Table 4.5. Parameter Estimates for GMM model for depression.

	Parameter	Coefficient	Standard Error
Class 1 (35%)	Intercept Mean	13.884*	0.557
Improvers	Intercept Variance	31.505	3.393
	Slope Mean	-1.781	0.083
	Slope Variance	0.527	0.140
	Intercept - Slope	-0.780	0.059
	Correlation		
Class 2 (65%)	Intercept Mean	19.151	0.037
Non Improvers	Intercept Variance	31.505	3.393
	Slope Mean	0.037	0.457
	Slope Variance	0.527	0.140
	Intercept - Slope	-0.780	0.059
	Correlation		

Note: *indicates significant coefficients

Table 4.6 presents the results of analyses, indicating the association between several pre-treatment variables and class membership for both anxiety and depression. More specifically the chi-square tests showed that membership of both the anxiety ‘non-improvers’ class, and the depression ‘non-improvers’ class was significantly associated with being unemployed, and having a longer duration of current difficulties i.e. onset more than five years ago. Furthermore, members of the ‘non-improvers’ classes for both anxiety and depression were more likely to have demonstrated risk (of suicide), and were more likely to use medication. Neglect (of self or others) was more likely to be present in members of the depression ‘non-improvers’ class but this was not significantly associated with class membership for anxiety.

In regards to other treatments, ‘non-improvers’ in both anxiety and depression were more likely to have received previous treatments and were more likely to be receiving other treatments concurrently with LICBT. Comorbidity within initial diagnoses was also associated with class membership; both classes of ‘non-improvers’ were more likely to have received a baseline diagnosis of mixed depressive and anxiety disorder. The association between class membership and gender was not statistically significant for depression or anxiety.

Table 4.6 Chi-square tests of associations between pre-treatment variables and class membership for anxiety and depression

	Anxiety			Depression		
	Improvers N=207	Non-Improvers N=43		Improvers N=219	Non-Improvers N=32	
	N (% of specified category within classes)			N (% of specified category within classes)		
Female	122 (58.90)	29 (67.40)	$\chi^2(1) = 1.077\ p = .299$	131 (86.80)	20 (59.80)	$\chi^2(1) = .084\ p = .772$
Unemployed	98 (47.80)	32 (74.40)	$\chi^2(1) = 10.094\ p < .01$	106 (48.80)	24 (75.00)	$\chi^2(1) = 7.644\ p < .01$
Suicide risk	39 (18.80)	17(39.50)	$\chi^2(1) = 8.772\ p < .01$	44 (20.10)	12 (37.50)	$\chi^2(1) = 4.882\ p < .05$
Using medication	123 (59.40)	36 (83.70)	$\chi^2(1) = 9.082\ p < .01$	134 (61.20)	26 (81.30)	$\chi^2(1) = 4.863\ p < .05$
Onset > 5years	16 (11.80)	8 (26.7)	$\chi^2(1) = 4.413\ p < .05$	17 (11.6)	7(33.30)	$\chi^2(1) = 7.018\ p < .01$
Neglect of self or others	21 (10.10)	5 (11.60)	$\chi^2(1) = .084\ p = .772$	19 (8.70)	7 (21.90)	$\chi^2(1) = 5.239\ p < .05$
Received previous treatments	92 (44.40)	29(67.40)	$\chi^2(1) = 7.540\ p < .01$	99 (45.20)	23 (71.90)	$\chi^2(1) = 7.950\ p < .01$
Received additional treatments	16 (7.70)	9 (20.90)	$\chi^2(1) = 6.894\ p < .01$	16 (7.30)	9 (28.10)	$\chi^2(1) = 13.494\ p < .01$
Comorbidity	80 (38.80)	28 (65.10)	$\chi^2(1) = 10.004\ p < .01$	89 (40.80)	19 (59.40)	$\chi^2(1) = 3.913\ p < .05$

Two binary logistic regression models were tested, with class membership (improvers, non-improvers) as the dependent variable and demographic variables (age, gender) and risk factors (employment, risk, medication, onset, neglect, previous treatments, concurrent treatments, and comorbidity as predictors). To find the most important, and statistically significant, subset of variables, forward selection based on change of the log likelihood (likelihood ratio test) was used. The model for anxiety with 2 predictors was the optimal model and was statistically significant ($\chi^2=14.33$, $df = 2$, $p < .01$). Risk of suicide ($OR = 3.51$: 95% $CI = 1.44 - 8.58$) and receiving concurrent treatments ($OR = 4.10$: 95% $CI = 1.14 - 14.78$) significantly increased the probability of being in the non-improver class. The model for depression with 2 predictors was the optimal model and was statistically significant ($\chi^2=12.66$, $df = 2$, $p < .01$). An onset of five years or more ($OR = 3.70$: 95% $CI = 1.22 - 11.27$) and receiving concurrent treatment ($OR = 45.79$: 95% $CI = 1.53 - 21.87$) significantly increased the probability of being in the non-improver class.

4.4 Discussion

4.4.1 Discussion of chapter findings

Results were as expected for both depression and anxiety, given that there was one class representing improvement for each, one class representing no improvement, and furthermore, improvement was associated with clinically relevant baseline scores on both the PHQ-9 and the GAD-7 (Gyani, et al, 2013, Lutz et al, 2014). The emergence of one ‘improvers’ class and one ‘non-improvers’ class for both anxiety and depression is in keeping with previous findings (Lutz et al., 2009; Lutz et al., 2014), although increased variation has been reported in some of these earlier studies. Lutz et al. (2009) determined 3 classes, one of which represented non-improvement, and 2 of which represented various rates of positive response corresponding with initial symptom severity. Moreover, four variations of psychotherapy and pharmacological interventions were used, and treatment type was not found to be predictive of overall response. A more recent study predicting patterns of early response to a web based LICBT for depression similarly determined 2 classes of improvers (slow and rapid), and one non-improvers class. It may be suggested that ‘improvers’ in the current study also demonstrated less variation in initial symptom severity, explaining why there was no significant distinction between slow and rapid responders.

As expected, class membership was also determined to be predictive of treatment outcome; results indicate that 63.10% and 68.10% of participants scored below the thresholds for clinically relevant symptoms at session 6 for anxiety and depression respectively, and that 60.14% of clients scored below thresholds on both measures at

session 6. This is in keeping with recent IAPT outcomes which reported annual reliable improvement rates of 66.4% (HSC, 2018).

Delgadillo et al. (2014), found that reliable improvement rates increased in line with the duration of interventions, thereby indicating the presence of a dose-response effect which peaked at six sessions and demonstrated a tendency to reduce following seven sessions. Furthermore, results suggested that at least four sessions are required in order to achieve reliable improvements rates of more than 50%. Delgadillo et al. (2014), concluded that such early improvements in low intensity interventions were predictive of clinically significant recovery by the end of treatment after controlling for potential confounders including medication use, symptom severity at baseline, and pre-treatment symptom changes. The current results are therefore consistent with numerous studies which have highlighted the prognostic importance of early changes in more intensive therapy (Crits-Christoph et al., 2001; Kelly, Roberts & Cislea, 2005; Whipple et al., 2003). Importantly these findings reveal that the highest attrition rates are detected by session 4, suggesting that engagement and retention should be a key focus of sessions 1-3. Given that findings indicate 4 sessions at least are required in order to exceed 50% reliable improvement rates, there should thereby be a particular focus on those who do not demonstrate any early changes.

Delgadillo et al. (2014) have recommended that their prediction model be replicated and validated in other UK regions, in order to enhance generalizability to the wider primary care and IAPT fields.

Gyani et al., (2013) determined recovery was less likely to be achieved by those with greater baseline symptom severity. Similarly, the current study found higher estimated mean scores at baseline were associated with membership of the non-

improvers class for both depression and anxiety. This may be partly explained by the fact that LICBT is designed to treat mild to moderate level difficulties. Whilst some patients with initial severe symptom severity may still achieve gains throughout, and by the end of treatment, some of these patients require a referral to higher intensity care. It is therefore intuitive to suppose that the non-improvers classes were unsuitable for LICBT due to the severity of symptomatology (Clark et al., 2009; Richards & Whyte, 2011)

An exploration of the association between pre-treatment variables and class membership determined that members of both the depression and anxiety ‘non-improvers’ classes were more likely to be unemployed, to demonstrate suicide risk, to use medication, to have received previous treatments for MH difficulties, to be receiving concurrent treatments, and to have had a longer duration (onset) of difficulties (i.e. more than 5 years). Additionally, less improvement was associated with having an initial comorbid diagnosis. It may be reasonably suggested that several of the pre-treatment variables found to be associated with membership of the non-improvers classes are also indirect indicators of higher symptom severity.

As per the exclusion criteria described earlier, PWPs are not expected to treat people with significant levels of risk (UCL, 2014), which is supported by the finding that risk itself (both in terms of suicide and neglect) was a predictor of less improvement.

In relation to comorbidity, Gyani et al. (2013) established that achievement of recovery criteria was more probable following a baseline diagnosis of depression or general anxiety only, in keeping with the current findings. More recent research has similarly found comorbidity (of depression) to be associated with poorer treatment

response, and the persistence of symptoms in relation to anxiety (Delgadillo, Moreea & Lutz, 2016)

Prompt mental health care (PMHC), a Norwegian version of IAPT, found the predictors of less improvement during LICBT to be unemployment and the use of antidepressant medications (Knapstad, Nordgreen & Smith, 2018). It has been supposed that unemployment itself exemplifies a structural issue which may not always be within the client's control (Knapstad et al., 2018). It might be reasonable to assume that the person-centred nature of PWP work could be inadequate where these clients have more complex and enduring issues requiring higher intensity care. It has been well established that unemployment and mental health problems frequently co-occur creating a vicious cycle of sorts (Frasquilho et al., 2016; Olesen, Butterworth & Rodgers, 2012). Unemployment has been linked with social withdrawal and reduced self-esteem (Staiger, Waldmann & Krumm, 2017) which in turn impedes on job seeking behaviours (Maddy, Cannon & Lichtenberger, 2015). Indeed, among English IAPT clients, unemployment itself has been associated with the chronicity of depression and anxiety symptoms (Delgadillo et al., 2016). Reviews have determined briefer episode duration (more recent onset) to be associated with better treatment response (Hamilton & Dobson, 2002), again in keeping with the current and previous IAPT research results.

Current findings derived specifically from the logistic regression models, corroborate earlier IAPT research which highlights concurrent treatments as being predictive of reduced improvement (Gyani et al., 2013). It is reasonable to suggest that receiving previous or concurrent treatments, is itself an indicator of both the enduring and complex nature of difficulties, which consequently render a client potentially unsuitable for LICBT.

Knowledge about potential predictors which is gathered at the pre-treatment point, may be used to consider the likelihood of LICBT being effective for particular patients or sub groups of patients, and furthermore may aid decision making in relation to treatment continuation for individuals identified as being at risk of non-response (Krause, Howard & Lutz, 1998; Lutz, 2002).

Given that the IAPT model adheres to a stepped care framework of service provision, such information about potential predictors is extremely valuable (NICE 2011; van Straten, Hill, Richards & Cuijpers, 2015). Moreover, understanding the processes involved in early change is essential in terms of tailoring interventions to meet individual needs (Laurenceau, Hayes & Feldman, 2007). It may be suggested that the predictors identified here, could be considered in relation to modifying inclusion triage referral criteria for those seeking to access LICBT; will a patient with long term comorbid depression and anxiety benefit from LICBT within 6 sessions?

Should this patient be offered a higher intensity intervention first? Given that patients may also be ‘stepped down’ within the stepped care framework, this is something which should be considered; the least resource intensive *and* the most effective intervention should be offered first.

4.4.2 Limitations

The lack of a control group and random allocation were the main limitation of this current study; the clients who improved may have done so without the intervention. However, there have been many studies and reviews which have showed that longitudinal changes in anxiety and depression for LICBT participants are better compared to control group (Cuijpers et al., 2010; Knapstad et al., 2018). The time

period involved in the current study was relatively short in terms of examining change trajectories, although it represented the optimum number of sessions recommended for LICBT within IAPT (Clark et al., 2009). In relation to pre-treatment predictor variables, the possibility of self-report bias cannot be excluded, nor can potential confirmatory bias from practitioners in relation to the subjective interpretation of this information.

4.4.3 Future Research

Knowledge in relation to the predictors of response to LICBT treatment is relatively low, particularly in the context of NI. Further exploration of this is required in order to improve the accuracy of suitable patient profiles and exclusion criteria as per a stepped care framework, in accordance with NICE guidelines. Lutz et al. (2014, 2017), suggest that future research should focus specifically on homogenous and heterogeneous diagnostic groups and treatment settings.

More research is also needed to further understanding about the factors which contribute to positive early treatment response, and which of these factors might indicate risk of deterioration and discontinuation of treatment.

4.4.4 Chapter Conclusion

Early response patterns have been shown to be associated with outcomes across different disorders (Bradford et al., 2011; Lewis, Simons & Kim, 2012); different treatment modalities (Crits-Christoph, 2001; Gunlicks-Stoessel & Mufson, 2011), and different psychometric measures (Hunter, Muthen, Cook & Leuchter, 2009). Early response change profiles can be predictors of treatment outcomes (Lutz, Stulz & Kock, 2009; Stulz, Lutz, Leach, Lucock & Barkham, 2007). Practitioners may also use typical change patterns as a benchmark in order to compare patient progress

(Lutz, Stulz, Martinovich et al., 2009) and knowledge of such profiles may also facilitate identification of the most promising intervention for a certain patient before it is initiated (Lutz et al., 2006).

The current findings provide further evidence for the clinical effectiveness of LICBT, given that the majority of the sample were in an ‘improvers’ class for both depression and anxiety, and these classes had mean scores below the thresholds for clinically relevant symptoms after the recommended six sessions of treatment.

Importantly, a number of pre-treatment variables have been determined as predictive of less improvement; these factors (employment status, use of medication, risk of suicide and neglect, onset of difficulties, previous and concurrent treatments, and comorbidities), could be carefully considered by practitioners as potential risk factors for poor treatment response.

Currently only one of these factors (risk) is listed as a specific criterion to discuss a client within clinical case management supervision for PWPs; progress for clients meeting these other criteria could therefore be reviewed before the completion of six sessions, or highlighted in initial clinical supervision sessions, in order to ensure that access to appropriate and timely care is not impeded.

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Chapter 5

How can we improve access to mental healthcare in NI?:A qualitative study exploring the perspectives of PWP service providers

Chapter Overview

The current chapter employed a qualitative methodology, specifically interpretative phenomenological analysis in order to explore the perspectives of PWP service providers. The investigation focused largely on service providers' feelings about the PWP service model, and also considered perspectives about access to mental healthcare services in Northern Ireland generally. A number of super ordinate and sub ordinate themes were uncovered. These related to the perceived benefits of the PWP service, but also to potential improvements that could be made. The themes uncovered in relation to general services in NI, suggested several barriers to service improvement and development, of both an attitudinal and systemic nature, although some hope for future positive development was also conveyed. Whilst quantitative evidence has thus far provided preliminary evidence for the clinical effectiveness of a PWP service model in NI, the importance of real experience in relation to the operation and delivery of the service must be regarded if future service developments are to be successfully designed and implemented.

5.1 Introduction

5.1.1 Improving ‘access’ requires more than clinical effectiveness

Chapter 4 revealed a number of factors which were predictive of treatment response or non-response. This reinforces the importance of providing an individual with the right treatment at the right time, delivered by the right person in the right place. In terms of clinical effectiveness, it is certainly useful to know what may or may not impact treatment response and outcome.

However, there remains a need to know how access and attendance at effective services may be improved. Moreover, is a clinically effective service truly effective if it is not adequately accessible?

As outlined in the introductory chapter, it is important to reflect on the meaning of the word ‘access’ in the context of improving access to psychological therapies. Importantly, access in this case endorses a number of interwoven concepts which include availability, utilization, effectiveness and equity (Gulliford et al., 2001), as well as efficiency and adherence to a patient centred approach (Bennet-Levy, Richards & Farrand, 2010). The clinical effectiveness of LICBT as delivered by PWP has been determined in the UK (Gyani et al., 2013), and in the current study with regards to Northern Ireland (McDevitt-Petrovic et al., 2018). It can also be accepted that PWP services advocate a patient centred approach, given that treatment plans acknowledge patient choice and there is a clear focus on collaborative care and shared decision making. It is vital however to consider how PWP services in NI as they continue to develop, might reflect the other aforementioned concepts associated with improved access.

5.1.2 Availability and efficiency

More specifically, it is now important to ensure that availability is adequate; there should be ample funding to facilitate a sufficient supply of services and these services must subsequently be utilized by the appropriate individuals within a functioning stepped care framework. Utilization is further impacted by the perceived acceptability of services, in addition to physical accessibility and financial cost. Efficient services refer to those which ensure both individual patients and entire populations benefit by offering treatment in a cost-effective way. Indeed as indicated in Chapter 1, potential cost benefits were instrumental in supporting the rationale for nationwide implementation of the IAPT initiative in England (Clark et al., 2009; Radhakristan et al., 2014). Furthermore, in order to optimise possible cost benefits, the stepped care approach within which IAPT services operate, stipulates that the most effective yet least resource intensive interventions should be provided first.

5.1.3 Initial contact, equity and utilization

A high proportion of individuals with mental health difficulties do not access care (Wang et al., 2007), or fail to continue with treatment once initiated (Edlund et al., 2002; Olfson et al., 2009). More specifically it has been previously determined that 52-74% of individuals with mental health difficulties do not receive treatment in Europe and the US (Kessler et al., 2005; Wittchen & Jacobi, 2005; Thornicroft, 2007). Access to services can be impeded by a lack of knowledge regarding the clinical indications of mental health difficulties; people who fail to acknowledge problems frequently endure them alone, and help-seeking is often complicated and prolonged (Tanskanen et al., 2011).

Analysis of national IAPT data have identified groups which tend to be under represented within services: men, ethnic minorities, refugees, asylum seekers, prisoners, ex-prisoners, veterans, LGBT, social deprivation, carers, older adults, disabled and learning difficulties (Clark et al., 2009). It is reasonable to assume that these groups may also be underrepresented in NI services.

It has been well established that delayed access to the appropriate intervention can result in further complications, and the duration of untreated illness in depression and anxiety disorders is associated with poorer outcomes (Dell’Osso, Glick, Baldwin & Altamura, 2013). Furthermore, inadequate utilization which includes dropping out of interventions and a failure to adhere to them are common after treatment is initiated. (Barrett, Chua, Crits-Christoph, Gibbons & Thompson, 2008).

The term ‘adherence’ is now preferred to ‘compliance’ as it reflects a more progressive pathway towards understanding why people do not engage with interventions (Corrigan, Morris, Michaels, Rafacz & Rusch, 2012). Financial issues, transport issues, low levels of satisfaction with service provision, and inadequate support throughout the course of treatment are among the most frequently cited reasons for this (Edlund et al., 2002; Olfson et al., 2009; Kovandzic et al., 2011). It is widely recognised that untreated mental health difficulties have personal, social and wider economic consequences (Knapp, 2003; Andrade et al., 2014).

5.1.4 Common barriers to access

An extensive body of research has examined potential barriers to accessing mental health care; these have been identified separately as knowledge based, attitudinal or structural (Thompson, Hunt & Issakidis, 2004).

Knowledge based barriers include a failure to realise the presence of a mental health disorder and being unaware of how and where to access appropriate help. Attitudinal barriers include those associated with stigma, reluctance to disclose personal information and a desire to deal with difficulties alone, and beliefs about the potential helpfulness of professional care. Structural barriers include financial concerns, issues with transport and lack of available and appropriate services (Mackenzie, Erickson, Deane & Wright, 2014). Some of the more commonly reported attitudinal barriers to help seeking for mental health difficulties include a desire to deal with the problem lone (Gulliver et al., 2010, Rickwood, Deane & Wilson, 2007; Wilson & Deane, 2012), believing problems will go away by themselves, negative beliefs about the benefits of accessing help (Rickwood et al., 2007; Rughani, Deane & Wilson, 2011; ten Have et al., 2010), and stigma related worries (Gulliver, Griffiths & Christensen, 2010; Pescosolido et al., 2010).

Mackenzie et al., (2014) conducted a 40 year cross-temporal meta-analysis in order to examine changes in attitudes towards accessing mental health services. A key finding of this review was that such attitudes among American university students have become increasingly negative throughout this 40 year period, which corroborates suggestions that public stigma regarding mental health has either remained the same or worsened over time (Angermeyer, Holzinger & Matschinger, 2009; Pescosolido et al., 2010).

It has been suggested that increased attempts to conceptualize mental health problems as biological diseases may at least partly account for the simultaneous increase in negative attitudes towards accessing mental health services.

Alternatively, it is feasible that a greater tolerance of high stress is now merely expected as part of everyday life (MacKenzie et al., 2014)

As highlighted previously, studies to date have frequently highlighted attitudinal barriers to mental health treatment associates with negative beliefs about health, negative beliefs about treatment consequences, and stigma. (Jagdeo, Cox, Steen & Sareen, 2009; Prins, Verhaak, Bensing & van der Meer, 2008; Sareen et al., 2007), and many individuals with mental health difficulties do not recognise that psychological interventions may be beneficial (tenHave et al., 2010). Clement et al. (2015), reviewed 144 qualitative and quantitative studies in order to explore the impact of mental health related stigma on help seeking, and concluded stigma had a small to moderate-sized negative effect on help-seeking. Stigma has been found to impede help-seeking at personal, provider, and systemic levels (Corrigan, Druss & Perlick, 2014).

Self-stigmatisation and the desire to avoid being labelled may be linked with a preference to deal with problems alone (Andrade et al.,2014). Public attitudes towards mental health difficulties and a fear of being discriminated against at work may prevent some people from declaring their own mental health history (Corrigan & Wassel, 2008; Mehta, Kassam, Leese, Butler & Thornicroft, 2009; Wheat,Brohan, Henderson & Thornicroft, 2010).

Andrade et al. (2014) examined barriers to the initiation and continuation of mental health treatment among individuals with common mental health problems using the WHO World Mental Health Surveys. The outcomes for respondents who had DSM-IV disorder in the past year were analysed. The most common reason for failing to initiate treatment was low perceived need which itself was more prevalent among mild-moderate cases compared with the more severe. Women and younger people were more likely to realise a need for treatment.

Among those who did, a subsequent desire to deal with problems alone was the most common barrier to access. These attitudinal barriers were significantly more important than structural barriers in mild to moderate cases. However structural barriers had the stronger influence on both initiation and continuation of treatment in more severe cases. The most frequently recorded reasons for treatment dropout were perceived inefficacy of therapy and negative experiences with service providers. Negative experiences of initial service access have been reported to be associated with service provider attitudes, lack of openness and a failure to listen well (Tanskanen et al., 2011; Morphet et al., 2012). The concept of self-determination acknowledges that people have a fundamental psychological need to feel empowered and capable when goal-seeking with others (Deci & Ryan, 2012).

5.1.5 Referral pathways, waiting times and non-attendance

The referral source has been found to impact attendance of appointments; poor communication between the referring professional and patient has been linked with a failure to attend initial appointments (Mitchell & Selmes, 2007). Patients who agree with their referral are more likely to attend appointments than those who don't (Killapsy et al., 2000). Mitchell and Selmes (2007), found that rates of both initial and subsequent non-attendance were higher among self-referrals compared with other service provider referrals. The assessor can also influence subsequent attendance of treatment. Attendance rates have been found to be lower with consultants such as clinical psychologists and psychiatrist compared with trainees (McIvor & Carson, 2004).

The waiting times between referral and initial appointment has also been linked with failure to attend (Gallucci, Swartz & Hackerman, 2005). Similarly, increased waiting times between assessment and commencement of treatment have also been associated with increased non-attendance at follow up appointments (Jackson, Booth, Maguire & Salmon., 2006).

The therapeutic alliance and the level of ‘helpfulness’ perceived by the patient is an important interpersonal predictor variable of attendance (Johansson & Eklund, 2006). Some research has indicated however that practitioner rated alliance is a more reliable predictor of disengagement than a patient rated therapeutic alliance (Meier, Donmall, McElduff, Barrowclough & Heller, 2006).

Although there have been considerable efforts made within IAPT services to facilitate patient choice as per a stepped-care approach, and across different treatment modalities, non-attendance rates have remained at around 47% (Richards & Borglin, 2011). The findings reported by Marshall et al. (2016) indicate a possible need for services to improve collaboration with GPs. They also highlight potential difficulties when trying to maintain a patient centred approach, given that IAPT practitioners are required to manage large caseloads (Richards and Borglin, 2011). Furthermore, this itself may have contributed to the experiences of respondents who were dissatisfied with the therapeutic relationship.

Marshall et al. (2016) suggested a number of strategies to reduce nonattendance including making and maintaining contact with those on waiting lists in order to lessen feelings of being neglected. They also proposed that perceptions of care might be improved by enhancing service and GP collaboration.

Patient expectations of interventions could be better managed by providing adequate pre-treatment information regarding the purpose and length of the assessment, details about the practitioner and treatment options. Increased flexibility in how interventions are delivered could improve patient experience and attendance, and small modifications in practitioner style, manner and skills could help reduce rates of treatment drop-out. Services must be responsive to patients' needs and to communicate with them regarding problems around attending and engaging. Learning more about such difficulties represents an opportunity for services to engage with the individual, as well as an opportunity to learn more about how best to deliver psychological therapy for those in need.

5.1.6 Key issues for service access in NI

Whilst the above mentioned key issues have been highlighted and discussed in Chapters 2 and 3, it is useful at this point to reiterate and summarise some of these in order to consolidate the objectives of the current chapter.

It is clear there are distinct differences in how services are set up in NI compared with other regions in the UK, and more specifically when compared with the IAPT service model. As described in the introductory chapter, IAPT services operate within a broader system of healthcare commissioned by local CCGs. The service model covers both primary and secondary mental health care usually with a central management and administration hub, maintaining strong links with community sector organisations and primary care services, consequently facilitating improved access for individuals at a local level (Clark et al., 2009). Moreover, the flexibility of referral pathways has also increased, given that individuals may self-refer or be referred at the community and primary or secondary care level.

The primary aim is to deliver the correct treatment at the right time and in the right place, which requires IAPT services to maintain strong communication with a wide range of healthcare professionals (Clark et al., 2009; Gyani et al., 2013).

In NI the pathways to care for people with common mental health difficulties remain unclear, and as highlighted previously, there is no option to self-refer to psychological talking therapies as in IAPT. Furthermore, the mental health service framework in NI does not formally apply evidence as per NICE clinical guidelines, which inform English IAPT services (HSc, 2014). The reviews described in Chapter 2 have reported that improved access to psychological therapies including CBT is still needed in NI, and recommendations have been made to outline a new ten year mental health strategy incorporating a mental health advocate who would consolidate work across local government departments. (Betts & Thompson, 2017).

Furthermore, although the efficacy of early interventions such as LICBT is most strongly evidenced with depression and anxiety (Gellatly et al., 2007; Ekers et al., 2014), and although such approaches are shown to be cost-effective in the long term (Layard, Clark, Knapp & Mayraz, 2007), a stepped care model has not yet been fully established in NI (Blane, Williams, Morrison, Wilson & Mercer, 2014). In 2013, the Northern Ireland Mental Health Services Threshold Criteria acknowledged that low intensity therapists working at stepped care levels one and two, including those delivering low intensity interventions are crucial for the establishment of an effective stepped care approach to psychological therapy provision in the province (HSC, 2014).

It should be recognised also, that services cannot be improved by the current and significant political instability in NI, the absence of a functioning local government and consistent inadequate funding (McHugh & Barlow, 2010; Betts & Thompson, 2017; Seward & Clark, 2010).

5.1.7 Aims

In keeping with the aims of the previous empirical chapters, which sought to present initial evidence for the clinical effectiveness of the PWP service in NI, the current chapter seeks to present the qualitative evidence for the effectiveness (or not) of this service in terms of how access to psychological therapy provision may be improved by PWPs. The perspectives of those who have been involved with the facilitation, implementation, management and/or supervision of this new service model in NI will be explored and analysed. These perspectives may provide useful insight with regards to how key issues within mental healthcare provision in NI may be addressed and more precisely in relation to how the PWP service model fits within this. The chapter aims are as follows:

- To explore the experiences of those involved with the facilitation and implementation of the PWP service in NI.
- To explore the perspectives of these service providers in relation to the efficiency and effectiveness of the services
- To explore the perspectives of these service providers in relation to how access to psychological therapies in NI could be improved.

5.2 Method

5.2.1 *Design and methodological rationale*

The philosophical underpinning for the research, was that the perceived success (or not), of this newly implemented PWP service model, would be based on the individual service provider experience of it (and other personal and professional experience), and moreover would be based on their subsequent relation to phenomena. As a researcher, it was necessary to consider possible connections between the assumptions held about reality (ontology), and the ways in which the carrying out the research might lead to the development of meaningful knowledge (epistemology). A subjective and interpretive position can contribute to valid knowledge, therefore a qualitative approach using semi structured interviews, and subsequently interpretative phenomenological analysis (IPA) was employed to address the objectives.

Qualitative methodologies facilitate the search for meaning and understanding, and therefore include interviews and language-based analyses, usually informed by inductive logic (Savin-Baden & Major, 2013). The fundamental features of qualitative research have remained consistent with the primary focus on exploring and attempting to identify and individual's thoughts, perspectives and feelings using thorough and complex analysis (Ormston, Spencer, Barnard & Snape, 2014). This analysis enables the researcher to explore meaning and process in the context of lived experience and can consequently uncover new insights (Smith, Flowers & Larkin, 2013).

Smith and Osborn (2003) refer to IPA as a double hermeneutic, as participants try to “make sense” of their world, and researchers to “make sense” of this sense – making. This idiographic approach is compatible with the objectives of the study. IPA is a

qualitative, phenomenological and hermeneutic approach which facilitates the exploration of how individuals make sense of their experiences and the meanings they attach to them (Finlay, 2012; Smith et al., 2013) Phenomenology itself aims to explore and determine meaning and this meaning is interpreted by hermeneutics (Rennie, 2012).

IPA involves a two stage interpretation process given the analyst must make sense of the participant's sense making (Larkin, Watts & Clifton, 2006; Pietkiewicz & Smith, 2014). Idiography is also an important component of the IPA process whereby unique experiences are examined requiring thorough and systematic analysis of each individual narrative (Smith et al., 2013).

A mixture of critical and empathetic hermeneutics, allows for more detailed interpretation (Smith and Eatough, 2006). Smith and Eatough, (2007) posited that the critical realist epistemology of IPA, assumes a connection between words, and thoughts and feelings, while acknowledging this may not be taken consistently at face value; subsequent analysis is indirect. The need therefore to develop interpretation rooted firmly in the individual's narrative is highlighted, with need for analysis to be thorough and systematic (Smith et al., 2013). This study seeks to explore reflections on previous experiences and current issues. IPA was utilised in order to facilitate enhanced data analysis and will be examined through current literature and theories.

During the final stages of IPA, investigators must endeavour to extract general themes from the collective group of participants whilst staying true to individual narratives (Smith & Eatough, 2006).

The use of IPA is increasing within social science research (Smith, 2011), and this specifically includes several studies involving IAPT services (Baddley, 2014; Gyani et al., 2013; Shepherd, 2014; Steen, 2015). The idographic characteristics of IPA make it preferable to other qualitative methodologies (Savin-Baden & Major, 2013; Steen, 2015).

5.2.2 Participants, sampling and recruitment

The sample design for the current study was non-probabilistic and purposively selected (Robson, 2011; Palinkas et al., 2013). This is a frequently employed within selection processes in qualitative research given that it promotes the recruitment of well-informed participants (Palinkas et al., 2013). Moreover, purposive sampling reduce the biases associated with snowball or convenience sampling given that participants are not recruited purely based on availability (Lucas, 2014; Robson, 2011).

Recruitment of all eight participants across NI was achieved via this method after ethical approval was obtained (see Chapter 2, section 2.9). Specifically, a total of 20 service providers and supervisors across 6 sites (3 Western Trust sites and 3 community sites) were invited to participate and were provided with a copy of the information sheet (see Appendix J). Those who expressed an interest also had researcher contact information and were therefore able to obtain further verbal details of the research initiative before deciding whether to participate. Consent forms were subsequently reviewed and signed by those agreeing to participate at this point (see Appendix K). Table 5.1 outlines participant characteristics; pseudonyms were used in order to protect identity.

Participants in the current study have characteristics and expertise which allow for a thorough exploration of how the service has been implemented. Understanding how effective (or not) the PWP service in NI has been, requires consideration of the experience of those facilitating services at the local level which is keeping with the aims. Small sample sizes are recommended for IPA to facilitate more thorough analysis (Smith et al., 2013). A critical review of IPA sample sizes concluded the optimum range to be between one and 35 (Brocki & Wearden, 2006); a sample size of 3 to 6 is recommended with an emphasis on quality over quantity (Smith et al., 2013). Considering this, and with the acknowledgement that the current study is within a doctoral thesis, a sample size of eight was used.

Table 5.1 Participant Characteristics.

Pseudonym	Gender	Job description
Mary	Female	Referral co-ordinator (Health Trust)
Emma	Female	Service manager (community sector)
Brian	Male	Clinical supervisor and CBT therapist
Aileen	Female	Service manager (community sector)
Brenda	Female	Referral manager (community sector)
Olivia	Female	General Practitioner (Health Trust)
Lisa	Female	GP practice manager (Heath Trust)
Dawn	Female	Referral co-ordinator (community sector)

5.2.3 Data Collection (*semi-structured interviews*)

Semi-structured interviews lasting 30-60 minutes were conducted, audio recorded, and transcribed verbatim for each participant. The interview schedule, (see Appendix M) included open ended questions such as “Can you tell me how...” The interview aimed to explore and inform regarding individual perspectives, therefore the schedule guided as opposed to dictating. Probes such as, “could you tell me more about that?” were also utilised in order to further explore significant revelations. A sample transcript is provided (see Appendix N).

The semi-structured interviewing process enables increased flexibility when compared with more structured interviews given that the researcher can scrutinize and probe novel topics of interest (Robson, 2011; Smith et al., 2013). Such a flexible approach to data collection is required for subsequent IPA/ thorough analysis of complex phenomena.

However, it is essential to have an interview schedule even where the interview itself is only semi-structured. This ensures that the focus is fixed on phenomena relevant to the research objectives, and these can be further explored. Although inductive processes are emphasised more in relation to IPA, a reciprocity with deductive processes is recognised (Chan, Fung & Chien, 2013).

In accordance with recommendations, secure and private settings were used for interviewing, and these were also convenient for and familiar to participants (Bryman, 2012).

Eight participants were interviewed at times and locations agreed upon by them; data was collected between June and October 2018, throughout NI.

After the interviews, notes were made in relation to how it progressed and in relation to what immediately emerged whether expected or unexpected (Biggerstaff & Thompson, 2008; Smith et al., 2013). Reflexive notes were also made (further details on reflexivity are described later in this section. The notes made immediately following the interviews involved reflecting on my own interpretations during the interview and these were subsequently referred to during transcribing in order to subsequently aid the process of analysis.

Participants were also debriefed following the interviews, specifically in relation to anonymity, and how the data would be used. They were invited to keep a copy of signed consent forms and information sheets.

5.2.4 Details of the analytic process.

The IPA framework involves a case by case approach whereby themes are classified, organised and summarised in tabular format, after which master themes are identified, extracted and explored (Smith et al., 2013).

All transcripts were read several times in order to achieve familiarity. The left hand margin of the transcripts was used to note initial ideas; observations were further sub categorised as being descriptive, linguistic or conceptual in nature (Smith et al., 2009). The right hand margin was used to record emergent themes, and issues conceptualised. This process also involved listening to the audio recordings while rereading, to maintain the sense of connection between the individual account and interpretation (Smith et al., 2009).

Repeated listening of interviews and repeated reading of transcripts enables exploration of phenomena at specific and general levels, ultimately facilitating a more thorough analytic process (Savin –Baden & Major, 2013).

Following this, relationships between themes were identified in order to facilitate the formation of clusters, and hierarchies of superordinate (master) themes, and their components, identified as subordinate themes (Smith et al, 2009).

Clusters were assigned descriptive labels and were titled according to several factors, including the prevalence and depth of text. The process was repeated for each of the participants. A table identifying recurrent themes across the group and tables of superordinate and their subordinate themes with accompanying data extracts were also created. These extracts convey the relevant themes to facilitate independent audit of the legitimacy of the interpretation (Smith and Eatough, 2006). A full narrative was developed as a means of writing up the analysis; this incorporated detailed commentary on data extracts guiding the reader through interpretation theme by theme as per the tables. This necessitated a coherent and distinctive balance between the presentation of interpretation and description of the participant narrative (Smith and Osborn, 2003).

5.2.5 Reflexivity.

It is important for the researchers to adopt an open-ended approach in relation to patient narratives (Chan et al., 2013). Given that the qualitative analyst must make sense of how phenomena emerge (Smith et al., 2013), it is considered important to acknowledge that their perspectives may be influenced by personal beliefs and experiences; analysts are therefore advised to be aware of this and to remain open to the possibility of data being contradictory to their own preconceptions (Larkin et al., 2006; Smith et al., 2013). As a result of this it is important to engage in reflective practice, as one may not actually be fully aware of their own preconceptions prior to data analysis (Pietkiewicz & Smith, 2014; Smith et al., 2013). Qualitative research

frequently includes the use of inductive logic whereby the analyst disregards prior knowledge and experience (Ormston et al., 2013; Pringle, Drummond, McLafferty & Hendry, 2011).

It has been posited however that this may be unnecessary and impossible given that inductive research will always extract and interpret data based on assumptions derived deductively from previous knowledge and experience (Blaikie, 2007; Finlay, 2012; Smith et al., 2013). Reflexive analysis acknowledged and evaluated the impact of my own experiences both personal and professional, and how these may have impacted data collection and analysis. This has been considered using self-reflection and a reflective diary which enhanced my awareness of my own preconceptions; extracts of this are detailed below.

'I was among the first cohort of PWPs trained here in NI while completing my MSc in 2015. As a PhD researcher evaluating the impact of the service in NI, I realise it is almost impossible for me to disregard my personal feelings and experiences as a practitioner. I have invested a great deal of time and energy into promoting the benefits of the service, and obviously I have witnessed the improvements and recoveries of my own clients first-hand. Whilst I understand the PWP service model in NI in its current form is not perfect, I appreciate I am not fully aware of the reasons for this. I have been quite surprised by some of the points raised by some service facilitators – it is clear there is more required to implement a new service model than establishing clinical effectiveness.'

The potential implications of the above in relation to the present study should be regarded. Although a degree of confirmation bias was possible, I was confident that analysis was not significantly influenced by this, given that the focus was on the

perspectives of service providers as opposed to trainee PWPs or qualified PWPs. Furthermore, there were a number of sub-themes which I did not quite expect to uncover.

Literature reviews were conducted both prior to and following data analysis in order to limit the potential influence of prior knowledge, and to prevent restricting the range of interpretation. It is also possible that my personal experience enhanced the analysis and enabled me to distinguish and subsequently reflect on the meanings of subtler data which contributed to themes. This research experience, whilst emotionally and practically demanding at times, reminded me of the importance of the diversity of individual perspective and experience, and furthered my understanding of the impact of my own experiences as a PWP and researcher, as well as those with more clinical experience who facilitated the PWP service.

5.2.6 Trustworthiness and credibility

It is not possible to conduct formal reliability testing in qualitative research given that the methodologies used are not standardised. Savin-Baden & Major. (2013) specify criteria to improve trustworthiness, many of which were applied when relevant throughout the research process in the current chapter's study. Specifically this included methodological coherence (congruence between research objectives, methodologies, data and analysis), triangulation (repeating examinations of data/ consulting with colleagues), audit trail (description of the research process from start to end in order to identify other potential influences on the outcomes), and negative case analysis (actively identifying and extracting data which did not fit the findings in order to promote critical thinking and subsequent modification).

5.3 Findings and Discussion

5.3.1 *Description of superordinate and subordinate themes*

Emergent themes extracted from the transcripts, were categorised under two headings (see table 5.2): attitudes towards the PWP service and attitudes to services overall in NI. Further analysis led participants' experiences to be clustered around three superordinate themes. These best reflected the data set according to researcher interpretation and were named as follows: benefits of the PWP service, improving the PWP service, and challenges for future service provision in NI; from each of these, a number of subordinate themes were identified (table 5.3). The superordinate and subordinate themes were also scrutinised to identify and determine the degree of recurrence across the sample (see table 5.4). Some relevant data extracts representing superordinate and subordinate themes are presented in tables 5. 5 to 5.7. Data extracts and all identified themes are described and discussed below.

Table 5.2 Initial labelling of emergent themes

Attitudes towards PWP service: novel, filling a gap, impact, clinical effectiveness, access, referral options, early intervention, prevention, building resilience, poor awareness of service, availability, accessibility

Attitudes towards services overall in NI: inter-professional difficulties, political instability, under resourced, resistance to change, lack of funding, excessive waiting, poor leadership, culture of fear, attitudinal barriers, moving towards change

Table 5.3 Master themes for the group

Superordinate themes	Subordinate themes
Benefits of the PWP service	a) Clinical effectiveness b) Filling a gap
Improving the PWP service	a) Increasing awareness b) Increasing availability
Challenges for future service provision in NI	a) Attitudinal barriers b) Systemic barriers c) Hope and change

Table 5.4 Identifying recurrent themes across the group

Subordinate Themes	Mary	Emma	Brian	Annie	Brenda	Olivia	Lisa	Dawn	Present in 50% of sample
Superordinate theme : Benefits of the PWP service in NI									
Clinical effectiveness	✓	✓	✓	✓	✓	✓	✓	✓	✓
Filling a gap in service provision	✓	✓	✓	✓	✓	✓	✓	✓	✓
Superordinate theme: How we can improve the PWP service in NI									
Promoting awareness	✓	✓	✓	✓	x	✓	✓	✓	✓
Increasing availability	✓	✓	✓	✓	✓	✓	✓	✓	✓
Superordinate theme: Challenges for mental healthcare NI									
Attitudinal barriers	✓	✓	✓	✓	x	✓	✓	✓	✓
Systemic barriers	✓	✓	✓	✓	x	✓	✓	✓	✓
Hope for future change	✓	x	✓	X	✓	x	✓	x	✓

Table 5.5 Benefits of the PWP service: Data extracts representing superordinate and subordinate themes

Benefits of the PWP service: “an invaluable service”

Clinical effectiveness: “an excellent service at this stepped care level”

Mary: “giving people the confidence and realisation that they can do it”

Emma: “all PWPs were of a high calibre”

Brian: “has made a real contribution to the wellbeing of people in this area”

Annie: “it’s a good starting basis for anybody coming in through services”

Brenda: “I have had great feedback (from clients) about the PWPs.”

Olivia: “feedback from our patients has been very good.”

Lisa: “patient engagement is far better face to face”

Dawn: “the clients definitely benefit from the service and its highly praised”

Filling a gap in service provision: “It meets a need ”

Mary: “PWPs have a massive role at this level of services”

Emma: “you have a higher turnover of people in a shorter period of time”

Brian: “address mental health issues at the very early stages”

Annie: “That’s’ how we can see its’ working well.. we now have an influx of referrals”

Brenda: “we were able to move people along a lot faster”.

Olivia: “it’s just such a great resource”

Lisa: “you did miss the service when it wasn’t there”

Dawn: “has been excellent for helping people in that situation where they don’t quite need counselling or higher therapy yet”

Table 5.6 Improving the PWP service: Data extracts representing superordinate and subordinate themes

Improving the PWP service: “PWPs should be fully embedded into Primary care and community services”

The need to increase awareness: “no one knows them or what they do ”

Mary: “we have lived in a society which has been culturally minded in treating with medications”

Emma: “I don’t think there is a great awareness in the community”

Brian: “in NI, IAPT has not been embraced”

Annie: “there would need to be a drive and a push on the advertisement of it”

Olivia: “it just needs a bit more education probably but yes I think awareness is growing”

Lisa: “we were learning in the early days”

Dawn: “I don’t think people are very aware of the (PWP) service.. I think a bit more has to be done to increase awareness about what a PWP actually does”

The need to increase availability and utilization: “ Access is still pretty difficult”

Mary: “high number of referrals coming in at this level”

Emma: “for PWPs to work, time is of the essence”

Brian: “by the time you get seen , there’s a very good chance that is now a chronic problem”

Annie: “Because we don’t have a PWP with us at the minute I’m sitting with 18 people on my waiting list”

Brenda: whenever they see you’re making good progress with clients they just kept firing in, and firing in referrals.. we have a bit of a waiting list”

Olivia: “it would be great if we had direct access but we don’t”

Lisa: “I’m sure they would love to have the service onsite..its just about accommodation”

Dawn: “that’s one thing I would change about the service...how people can refer...”

Table 5.7 Challenges for NI: Data extracts representing superordinate and subordinate themes

Challenges for future service provision in NI: “we don’t even have a functional government”

Attitudinal barriers: “it is survival of the fittest”

Mary: “we have to change the mind sets of a lot of professionals in order to get it right”

Emma: “it has to be where everyone values and respects everyone’s opinion”

Brian: “IAPT has not been embraced in NI, and that is mainly to do with interprofessional difficulties”

Annie: “everybody is under pressure, everybody is getting stressed, and it’s getting worse and worse”

Olivia: “there’s still a long way to go”

Lisa: “there’s still a certain stigma”

Dawn: “there’s a sort of stigma still in NI around talking”

Systemic barriers: “why should our health service be any different to the rest of the UK?”

Mary: “like many services we have, the Talking Therapies Hubs are under resourced as well”

Emma: “I honestly don’t know regarding the stepped care model now”

Brian: “psychological therapies waiting list is, despite government pressures creeping up and creeping up..”

Annie: “If our politicians were more focused on the real deal stuff instead of fighting with one”

Olivia: “there’s just problems, problems, problems but there’s no solutions”

Lisa: “you hear every day about how bad services are”

Dawn: “it comes down to the government too, there’s nothing being done there unfortunately”

Hope for positive future change: “we’re moving towards the model that IAPT is networked by”

Mary: “enthusiastic GPs who are being taught differently about social models and not just sticking to medical models”

Brian: “now beginning to appreciate and now beginning to see how they can use PWP’s in the most positive way”

Brenda: “they are trying to use this more social model of care now rather than just a medical model”

Lisa: “you can see they are trying to do something with this new pilot”

5.3.2 Discussion of findings

1) Benefits of the PWP service

This superordinate theme reflected the positive feedback reported by interviewees in relation to the PWP service in NI (see table 5.5). These benefits were referred to in terms of the perceived clinical gains for service users (clinical effectiveness), and in relation to the perceived advantages for services in general (filling a gap in provision).

1a) Clinical effectiveness

All the interviewees referred to their views of how clinically effective the PWP service has been in NI, corroborating quantitative evidence of this (McDevitt-Petrovic et al., 2018). As highlighted earlier, it has been posited that the provision of LICBT and guided self-help interventions, constitutes ‘a revolution in mental healthcare’ (Bennet-Levy, 2010, p.3.) More specifically in the current evaluation, it was described as an “*excellent*” and “*invaluable*” service in terms of the benefits to service users. The PWP workforce were referred to as being of a “*high calibre*” (Emma). The LICBT work delivered by PWPs was reported as making a “*real difference to people with depression and anxiety*” and “*a real contribution to the wellbeing of people in this area*” (Brian). More specifically it was reported that PWPs have “*facilitated learning for people to understand their feelings, how to make a difference for themselves, and the behavioural changes they can make*” (Mary). Clinical effectiveness is hugely important in terms of improving access to care; the PWP service model endorses the important concept of self-determination described earlier, given that clients are empowered through collaborative goal setting fulfilling a fundamental psychological need (Deci & Ryan, 2012). Importantly it has been

suggested that LICBT potentially reduces the risk of recurrence and relapse because of the strong focus on guided self-help and encouraging individuals to increase self-management (Bennet-Levy et al., 2010; IAPT, 2011). Importantly one of the interviewees, a very experienced high intensity CBT practitioner and clinical supervisor, suggested that the clinical work of PWPs *“has earned the respect of mental health professionals in the area who realise there is a large body of people who can benefit from the PWP service”*

In one service, the trainee PWPs were employed as part of a social prescribing network. Several definitions of social prescribing (SP) have been referred to, however, in relation to psychological wellbeing, SP has been endorsed as a particularly useful non-medical way in which social difficulties can be effectively managed for those who also have mental health problems (Friedli, Jackson, Abernethy & Stansfield, 2013). The PWPs were reported as being *“100% effective as part of that social prescribing model”* (Brenda). This corroborates existing research evidence indicating that SP itself is beneficial to psychological wellbeing (Grant, Goodenough, Harvey & Hine, 2000; Morton, Ferguson & Baty, 2015; Polley & Dixon, 2016). The role of a PWP involves a commitment to collaborative care and the interventions are delivered very much as a form of guided self-help. Patients are therefore encouraged to be actively involved in decision about their own healthcare, to increase social contact and integration and to return to employment where relevant (Richards & Whyte, 2011). The low intensity approach also lends itself to the SP concept given that PWPs frequently refer patients to third party organisations within the community and voluntary sector in order to support behavioural activation.

The effectiveness of the PWPs was also highlighted by service users themselves as conveyed by the service providers interviewed. Specifically, while describing the post intervention assessment procedures used with clients at their service, one participant reported that they had received “*great feedback about the PWP*” and confirmed that the “*clients have told me it has been beneficial*” (Brenda). A second service which also utilises post assessment tools stated, “*whenever you look at our research and our client satisfaction questionnaires, the clients definitely benefit from the service and it’s highly praised.*” This was also reported by the participating GP who confirmed that “*feedback from our patients has been very good*”. Client feedback is considered to be an important way to inform decisions which subsequently result in service improvements (Coulter, Locock, Ziebland & Calbrese, 2014; NHS England, 2013), however current qualitative evidence in regard to client experiences of IAPT services is relatively limited. A recent study exploring client’s experiences of one to one low intensity treatments for common mental health difficulties within an IAPT service concluded that both therapeutic techniques and relationships contribute to effective treatment experiences (Amos, Morros, Mansell & Edge, 2018).

One participant compared the effectiveness of the PWP service to an online CBT course their service had facilitated a number of years ago and concluded that “*patient engagement was far better face to face*”. The observation that patient engagement with face to face therapy was better compared with a course delivered online, lends support to previous research findings which suggest guided self-help is superior to pure self-help in regard to predicting reliable symptom change (Gyani et al., 2013).

This particular study also determined that step up rates to higher intensity services were 25.7% and 54.5% for those who has received pure or guided self-help respectively.

1b) Filling a gap in service provision

This theme particularly reflected the impressions of participants that the PWP have addressed a gap in service provision, specifically that they have facilitated access to appropriate talking therapies at steps 1-2 in accordance with a stepped care framework. There was a consensus among all interviewees that the PWP service “*meets a need*” (Brian) and that PWP “*have a massive role at this (primary care) level of services*” (Mary). For these purposes and as “*as a short term intervention it has been invaluable*” (Mary). One participant described how demand for the service steadily increased after the initial introduction of the PWP and suggested, “*that’s how we can see its’ working well... we have an influx of referrals..* (Annie)

As discussed earlier, the lack of a properly functioning stepped care model for mental health in NI has been highlighted (Blane et al., 2014), as has the need for more low intensity therapists, which would address this issue (HSC, 2014).

Furthermore, observations by service managers that “*we are certainly getting people seen by the PWP a lot quicker than general mental health services*” (Mary), is encouraging when speculating as to whether access to appropriate treatment is actually improved or not by the provision of a PWP service. One service coordinator suggested that when compared with waiting times to access generic counselling within their service, clients “*were able to get access to the PWP a lot quicker*”.

It has been suggested that when compared with traditional mental health services including generic counselling, that LI interventions do indeed improve access and increase the speed of access to treatment (Bennet-Levy et al., 2010).

The benefits of adhering to a stepped care framework was also commented on, as one interviewee claimed that high intensity psychological services were “*getting weighed down with waiting lists so they are using us to take the people who are on the lower end..they refer people over to us because they know we can move faster*” (Brenda). The benefits of this quicker access for clients was also mentioned: “*it has been excellent for helping people in that situation where they don’t quite need counselling yet but they know there’s still something they need help with*”(Dawn)

It was suggested once again that a PWP service working as part of a social prescribing model could further improve access to appropriate care:

“*social prescribing is used a pathway to speed things up...for people to get support with things they don’t need to treat medically.. for referrals coming through social prescribing we were able to move people along a lot faster.*” (Brenda)

The sub concepts of increased availability and utilization in relation to improving access was also alluded to by one service manager, who pointed out that the “*timeframe is excellent, in the sense that you have a higher turnover of people in a shorter period of time*”(Emma). The benefits of being offered the right treatment at the right time, is important in terms of early intervention and the prevention of longer term and more chronic difficulties, as recognised by one interviewee who commented, if people “*address mental health issues at these very early stages, they can make recoveries within short periods of time.*” (Brian).

It was apparent that all the interviewees regard the PWP service as one which fills a gap in service provision in NI. Participants responsible for making referrals commented “*when they aren’t here, we miss them greatly and we’re finding we have to redirect things. It’s just such a great resource*” (Olivia)

2) Improving the PWP service

This superordinate theme represents the reported views of interviewees in regards to how the PWP service in NI in its current form, may be developed and improved (see table 5.6). The most prominent ideas for this related to promoting awareness of the PWP role and service, and to increasing availability of the service as per the subordinate themes discussed below.

2a) Promoting awareness

As outlined within the current thesis thus far, the PWP service model is a new one in NI. Although trainee PWPS have been working at a number of clinical placement sites throughout NI since early in 2015, several interviewees maintained there is little awareness of the service among the general public, including among those seeking to access help for psychological difficulties. Importantly one service coordinator also reflected on the fact that “*we have lived in a society which has been culturally minded in treating with medications*”(Mary). Poor awareness among clients (Hamilton et al., 2011), and indeed among primary healthcare professionals including GPs (Gyani et al., 2013; RCP, 2013), can impede timely access to appropriate care, and increase the likelihood of difficulties becoming more complex and chronic. It was acknowledged that awareness in terms of the suitability of referrals was low initially: *we were learning in the early days... the GPs are mindful of this now when they are referring patients* (Lisa).

Service provision can be negatively impacted by receiving an excess of inappropriate referrals as a result of inefficient referral practices (Clark et al., 2009; Glover, Webb & Evison, 2010; Stern, Hard & Rock, 2015). It is essential that those making onward referrals are aware of the appropriateness and availability of services. It has been reported that even when dealing with unsuitable referrals, practitioners can feel a responsibility to continue with treatment until they can find appropriate care resulting in some working outside their competency (RCP, 2013).

Studies to date have suggested that common mental health difficulties can be poorly detected by GPs; one such evaluation of an IAPT pilot site indicated that 95% of referrals were categorised as depression, yet 43% of these were determined to be anxiety disorders following a clinical assessment (Clark et al., 2009; Gyani et al., 2012).

Lack of awareness in relation to how and where to receive appropriate treatment has been highlighted as a common knowledge based barrier to accessing mental health care (Thompson, Issakidis & Hunt, 2008). One participating service manager stated that there was not “*great awareness*” within the community and furthermore declared “*if we could get more awareness of what a PWP is out there, you could maybe have a lot of prevention as well*” (Emma). Another declared that “*for ourselves in the community and voluntary sector there would need to be a drive and a push on the advertisement of it*” (Annie). It is reasonable to assume given the service is relatively novel, that patients seeking help may be more familiar with counselling or other similar roles and available services. Moreover, the actual referral pathways in terms of accessing PWPs differs between clinical placement sites, and it is again reasonable to assume that even where a patient is aware of the PWP service, they may not be aware of how best to access it.

The issue of awareness was also alluded to with respect to the patients being referred to PWPs. One service manager confirmed she “*wouldn’t say to someone we can send you to a PWP because it’s not really a comfortable word out there in the community yet.*” (Emma). This leads us to the question, how many patients who were actually referred to, and/or assessed and treated by PWPs were aware of the service they were accessing before initial contact? The benefits however, of involving PWPs at the community sector level and moreover within a social prescribing project in relation to awareness was also described:

In terms of awareness, we are on a better footing now because we have social prescribing, so as the project started coming on board with the PWPs then we started getting referrals but before that it was very slow (Annie)

In conclusion, we must contemplate how promoting awareness of the PWP service among the general public, and among those seeking help for mental health difficulties, might lead to improved access or not? Furthermore, “*how do we raise awareness?*” (Emma). One service manager suggested that “*it is up to the organisation to work with whatever partner they have to get that information out there*” (Annie)

It is also important to acknowledge that although the PWP service has been deemed clinically effective as suggested by quantitative and qualitative research evidence, how effective can it really be if is not adequately accessible? Moreover, how useful is it to promote awareness of a service which, whilst clinically effective, is not yet readily and widely available to all of those who could benefit from it?

It is also reasonable to suggest that service utilization may be impacted by how acceptable services are perceived to be, again reinforcing the idea that more could be done to promote the possible benefits of PWP to potential service users. This is perhaps best described by one interviewee who stated *“I think a bit more has to be done by doctors to increase awareness about what a PWP actually does..a lot of people come through the doors, not exactly knowing what they’re in for and it is not really their fault..(Dawn)*. It was also suggested however that awareness is gradually increasing with time as reported by one participant, *“the word CBT has kind of taken off it just needs a bit more education probably but yes I think awareness is growing you know.. (Olivia)*

Research to date also highlights the importance of being mindful that client’s may have poor awareness of services, particularly relatively novel services, and those within geographically problematic areas; as suggested by the current findings, this emphasises the need for promoting awareness and fostering stronger links with community and voluntary sector organisations (Brown et al., 2014; Turner, 2015; Savage et al., 2015).

2b) Increasing availability and utilization

The second subordinate theme relating to improvement of the current NI PWP service is associated with the perceived need to increase availability and utilization. Essentially this highlights the need to expand the service thereby facilitating easier and quicker access for suitable patients. As stipulated in the introductory chapter, the meaning of the word access in the context of IAPT services, refers not only to effectiveness but also to availability, equity, efficiency and utilization.

The high demand for services at this level was outlined, as one service facilitator commented there are a *“high number of referrals coming in at this level”* (Mary).

Despite reporting on the fact that PWPs do indeed seem to address a gap in service provision, concerns about waiting times were highlighted as a significant and ongoing issue by a number of interviewees; *“even getting assess in order to refer to a PWP, there is a waiting time created..”* (Emma). Another participant described the problems associated with providing a clinically effective service for which there was increasing demand and limited availability, and suggested that *“whenever they see you’re making good progress with clients they just kept firing in, and firing in referrals”*. (Brenda). One service co-ordinator who was waiting on a new trainee PWP to begin placement at the time of interview, reported that *“because we don’t have a PWP with us at the minute I’m sitting with 18 people on my waiting list”* (Annie)

It is been well established that long waiting times can lead to chronic and frequently more complex problems. Complications are more likely if access to appropriate care is delayed; the duration of untreated depression and anxiety is associated with poorer outcomes (Dell’Osso, Glick, Baldwin & Altamura, 2013), and as determined in Chapter 4, those with longer term difficulties were less likely to achieve a reduction in the severity of depression and anxiety symptoms with LICBT.

In terms of the PWP service, this can mean an individual who may have been suitable for LICBT at the point of initial referral, requires more specialist or higher intensity treatment by the time they are actually assessed, something which was also outlined by participants;

“if you’ve a mental health problem, and you’re even in the mild to moderate state, by the time you get seen , there’s a very good chance that is now a chronic problem” (Brian)

“some of the referrals we see here are bad because of the delay in access...for PWPs to work, time is of the essence” (Emma)

One participant also pointed out that people sometimes resort to private care, something which would be unnecessary for mild to moderate cases had they adequate access to low intensity interventions, and furthermore, not everyone requiring help has the means to access private healthcare

“I treat people who don’t need to be coming to a highly experienced and costly CBT therapist... they could be treated by a PWP in their own GP practice or community centre”

The ambiguity and variability of referral pathways within the PWP service model, has clearly impacted ease of access, and the fact remains that *“there is no clear pathway on how you can access PWP services in NI”* (Emma). Presently, GPs are only able to refer directly to a PWP if that PWP is working within their own practice; currently only two practices have a trainee PWP and the benefits of this for GPs and patients was referred to: *“I prefer having them in the building and being able to directly refer to them”* (Olivia)

For others who cannot avail of the service this way, access is more complicated. One service coordinator explained that *“access is still pretty difficult. if someone rang me and said could I have an appointment with a PWP, the answer is no....you need to go to your GP, and your GP needs to make a referral and that referral could take 6-12 weeks”* (Emma).

Following initial GP contact, referrals are subsequently triaged at a Talking Therapies Hub, after which they are passed on to the appropriate service, which itself is likely to have a waiting list. It is clear there could be faster and easier ways in

which to facilitate adequate access, thereby increasing the availability and utilization of the service. One participant, who is involved in triaging referrals reported that *“if GPs could refer directly, it would improve access even more for people to get their intervention quicker”* (Mary), and further suggested that she would like to see PWP *“fully embedded into services like mine (primary care) and out in the community services”* (Mary). Importantly the practical implications of trying to expand the services was also pointed out: *“that’s the main stumbling block for other GP surgeries...I’m sure they would love to have the service onsite..it is just about accommodation and capacity”* (Lisa)

Most of the interviewees voiced concerns in relation to referral options: *“I think it would be really great if there was a way for the clients to self-refer to a PWP service, without having to go through their doctor”* (Dawn). It should be recognised that the option to self-refer was only available at one community site in the current study; evaluative studies of IAPT services to date suggest that the self-referral option improves access to care for groups of patients who tend to be under represented in GP referrals (Gyani et al., 2013). However, one service manager expressed doubts about how self-referrals would be managed within primary care services, and expressed the view that *“if someone refers directly then what happens to the co-ordinator or their posts, so there is a fear also of letting a person self-refer..and how do you control that, who pays for that?”* (Emma).

Concerns regarding self-referral pathways have been raised before, namely that they may cause certain services to feel overwhelmed, or that they may favour certain types of client (Brown, Boardman, Whittinger & Ashworth, 2010; IAPT, 2008;

Mathers & Mitchell, 2010); evidence to date however, indicates that this is not the case (Brown et al., 2014; Clark et al., 2009; Gaynor & Brown, 2013). It has also been suggested that self-referral pathways might bypass the function of other important healthcare workers such as GPs, although as discussed earlier, self-referral has actually been found to improve treatment access among those who tend to be underrepresented in GP referrals (Gyani et al., 2013; Lovell et al., 2014).

Poor communication between referral sources and clients has been linked with the non-attendance of initial appointments (Mitchell & Selmes, 2007). Rates of non-attendance for both initial assessments and subsequent treatment sessions have been found to be higher among self-referrals compared with those referred by a health professional however (Mitchell & Selmes, 2007). Waiting times between initial referrals and assessments, and between assessments and subsequent treatment sessions have been linked with attendance and engagement problems (Gallucci et al., 2005; Jackson et al., 2006).

The possibility of widening access and availability was also considered in terms of modifying interventions currently provided by PWPs, specifically with the suggestion that “*PWPs instead of just working one on one, could be doing group programmes*” (Emma).

Overall the feeling conveyed by all participants was that in order to increase availability and utilization, and in order “*to make the service truly acceptable, we have to see change at a higher level where the people who make the decisions about the direction and provision of care in NI see PWPs as part of the package they can offer*” (Brendan). The challenges posed by this observation are explored further within the final superordinate and component subordinate themes.

Regardless of how different referral pathways operate, the collaboration and expertise of other professionals is essential and the benefits of this support has been highlighted following the implementation of IAPT services (Gyani et al., 2012; Knowles et al., 2013; Stern et al., 2015). Moreover, increased awareness and focus on NICE recommended evidence based interventions among GPs has been furthermore associated with improved access to IAPT services (Gyani et al., 2013).

Several measures have been recommended in order to enhance access and reduce non-attendance, many of which are characteristic of the PWP service model, and have also been implemented within the NI PWP service (Mitchell & Semes, 2007), including: explain purpose of referral and reduce waiting time until initial appointment, give direction and explain mechanisms of referral, offer options on afternoon appointments, home visits and dates for subsequent appointments, consider reminders 24 hours before, agree the approximate duration of treatment at the beginning, maintain a good therapeutic alliance, work in patient centred and collaborative manner, respond to missed appointments appropriately by contacting the patient, confirming they still want to attend, reassuring them, providing hope, identifying barriers and rescheduling.

It is imperative that services should be adequately accessible and appropriately utilized given that the decision to actually seek help in the first place is frequently complex and may itself provoke further anxiety (Anderson & Brownlie, 2011; Evans-Lacko, Henderson & Thornicroft, 2013). The potential cost effectiveness of a properly functioning IAPT type service model was acknowledged by the opinion that *“if there was proper investment in it, it would pay for itself”* (Brian). It can be accepted that the clinical effectiveness of the NI PWP service model has been established. How then do we ensure this service is available and efficient?

3) Challenges for future service provision in NI

The third superordinate theme captures the perceptions of participants in terms of what the key issues are within mental healthcare services in NI. More precisely these observations related to the challenges for future service provision and also to some potentially positive changes (see table 5.7). The emergent subordinate themes were associated with barriers to change, namely attitudinal and systemic barriers. A third subordinate theme reflected reported hope for positive future change.

3a) Attitudinal barriers

This theme related to the attitudinal barriers perceived among healthcare professionals, relating to a reluctance to change how services currently operate. Attitudinal barriers to help seeking among potential clients were also highlighted as a challenge in NI.

Access itself can be negatively impacted by a lack of knowledge regarding mental health difficulties, or indeed as reflected in an earlier subtheme, a lack of information about the actual services which are available, both of which can result in difficult and prolonged help-seeking (Tanskanen et al., 2011). Research has established that stigma related worries are common barriers to seeking and accessing help (Gulliver et al., 2010; Pescosolido et al., 2010). Some interviewees suggested that attitudes towards help seeking and the acceptance of psychological interventions for common mental health difficulties is still problematic in NI:

“so many people in our society who go to GPs and seek services or seek medications for things that medications are not going to change” (Mary)

“But there’s a sort of stigma still in NI around talking about getting help, and that is unfortunate” (Dawn)

As described in the Chapter introduction, studies to date have frequently highlighted attitudinal barriers to mental health treatment (Jagdeo et al., 2009; Prins et al., 2008; Sareen et al., 2007), and importantly have also highlighted that many individuals with mental health difficulties do not recognise that psychological interventions may be beneficial (tenHave et al., 2010). The participating GP in the current study also claimed that patients still have a difficult time *“accepting there are things that they can do with anxiety and depression rather than just medication...theres a long way to go yet.”*

It is reasonable to suggest that more work is need in NI in relation to stigma reduction. Even within the GP practice it was observed that *“there’s still a certain stigma to them coming here to these (PWP) appointments”*.

Attitudinal barriers among those responsible for organising and providing mental health care services in NI were also discussed. In relation to the PWP service, one interviewee declared the IAPT model has not been embraced in NI and suggested the reasons for that are *“mainly to do with interprofessional difficulties...in NI certain professionals did not want to open up the whole service in that way – they wanted literally to preserve their own professional status”* (Brian). Another service coordinator expressed similar views and suggested that *“we have to change the mind sets of a lot of professionals in order to get it right..there is a lot of resistance to change from that medical model”* (Mary). In relation to participants from the community and voluntary sector organisations, the same feelings were conveyed:

This is very much about a fear culture as well..community projects are fighting for survival..its survival of the fittest.. it has to be where everyone values and respects everyone's opinion..we all need to be on the one team"

How do we encourage a willingness to change among the relevant professionals in NI? It is worth noting that there were also difficulties in the earlier stages of implementing English IAPT services given that it involved incorporating workers considered to be 'non-IAPT' therapists; for some services, significant relational work and negotiation was necessary in order to transform service provision (Altson, Loewenthal, Gaitanidis & Thomas, 2014; Lewis, 2012). Involving everyone in service development and implementation work would ensure all involved feel valued (May & Finch, 2009); moreover, workforce input in relation to the design and subsequent implementation of services can improve job satisfaction and staff retention (Boswell et al., 2015; Wolpert, 2014). The challenges faced for the future of the PWP service in NI with respect to this, was perhaps best summarised by one interviewee:

"theres a challenge here – whether the people who are in favour of PWP can carry the day against those that re not, and those who are not are, I believe, to a degree, guilty of elitism...they need to realise there's more than enough work for all of us..we have nothing to fear from this, all we have is to gain from it"

3b) Systemic barriers

This theme reflected the frustrations expressed by interviewees regarding a perceived lack of leadership and decision making in NI. This was talked about both in relation to the impact on service providers and the impact on service users:

something has to change generally..everyone is burnt out right now in the health service..its going to take a lot of restructuring...people are ready to keel over before they are getting access to service...they are not getting the service they need in time, so they are deteriorating” (Emma).

The GP who was interviewed also suggested that under resourced services significantly limited options and claimed the current structure of services has “*taken all the power away from us(GPs)... even if we know what needs to be done they still have to go through this whole middle process which takes time and overwhelms the service”*

The lack of available and appropriate services has been highlighted as common structural barrier to accessing mental healthcare (Mackenzie et al., 2014), and problems with availability and utilization have been discussed in relation to previous themes.

Inadequate funding of services (an historic and ongoing issue in NI), due to poor institutional and government support presents challenges in relation to the dissemination and sustainability of treatments (McHugh &Barlow, 2010; Betts &Thompson, 2017; Seward &Clark, 2010). This suggestion was strongly supported by findings in the current evaluation:

“it’s about quantity now, and it’s all cost effectiveness rather than wellbeing”(Emma)

for ourselves funding is really restricted for counselling and talking therapies
(Annie)

I mean looking at the bigger picture, you hear every day about how bad services are.
(Lisa)

Most of the interviewees also expressed significant frustration, directed for the most part at the local government or lack thereof in NI presently:

“right now we don’t even have a functional government, we have no one sitting in Stormont..so we can write whatever paper we want, we can suggest whatever we want to do, but there is no health minister for NI right now”(Emma)

“they are not there making the decisions that going to change anything for this.. they are there fighting with each other” (Annie)

“it comes down to the government too,..... there’s nothing being done there unfortunately.. something needs to be done pretty soon or else it’s not going to be ok” (Dawn)

it’s just so disheartening, you think, theres just no hope for us..there are just problems, problems, problems but there’s no solutions (Olivia)

Given the absence of a local government executive in NI presently, it is difficult to predict what significant changes, if any, can realistically be achieved in the near future. However, based on the findings discussed in this qualitative evaluation, the fact remains clear, that significant changes *are* required nonetheless. The key to successful implementation of the English IPAT initiative involved seeking and achieving integration; stepped care has enhanced treatment responsiveness and the IAPT model has achieved greater equitable access to evidence based interventions for those with common mental health difficulties (Layard et al., 2012; Steen, 2015).

As highlighted in Chapters 2 and 3, in relation to service organisation in NI, a lot can be learned from the English IAPT programme, however it is also important to acknowledge that service provisions must be adapted in order to meet regional and local level needs (Clark et al., 2009). The implementation of local IAPT services in

England are affected by geographical locations, quality of transport, links to other services and casemix among others. Services are therefore refined in accordance with the requirements of their respective locations and their populations, once again highlighting the impact of many sociodemographic factors on mental health (Clark et al., 2009; Glover et al., 2010; IAPT, 2008; Richards et al., 2012).

The frustration of many service providers in NI is perhaps best captured by the observations of one interviewee who asked *“why should our health service be any different than it is in the rest of the UK, given that we are supposed to be part of the UK?..we are supposed to be offering a service that meets the needs of all the people that came to us.”* (Brian)

3c) Hope for positive future change

The final subordinate theme reflected the suggestions of 50% of the participants, who discussed some of their feelings of hopefulness that positive changes were not far away for mental health services in NI. Although earlier themes reflected attitudinal barriers and stigma, both among services users and providers, it was also observed that we have a *“new branch of young and enthusiastic GPs who are being taught differently about social models and not just sticking to medical models”*(Mary). This participant went on to claim that the *“Department for Health are opening up very much more to the social prescribing side. I think that allows us to move much more towards IAPT models”* (Mary). This observation was also made by a participant dealing with referrals in the community and voluntary sector who has noticed that GPs *“are trying to use this more social model of care now rather than just a medical model”* (Brenda). SP in many parts of the UK, has been found to be of particular interest to GPs given that up to 20% of patients might attend a GP

appointment actually seeking help for social problems (Polley & Dixon, 2016). The SP framework enables service facilitators to encourage relevant patients to engage with new and helpful ways to make behavioural changes (Kilgariff-Foster & O’Cathain, 2015; Dayson, Bashir & Pearson, 2013; Grant et al., 2000).

Another interviewee insisted that the work carried out by the PWP service in NI has not gone unnoticed:

“PWPs make a very valid and a very powerful contribution that I believe mental health practitioners in the area, the GPs in this area and voluntary and community groups in this area are now beginning to appreciate and now beginning to see how they can use PWPs in the most positive way”(Brian).

In September 2018, a new initiative to bring physiotherapists, mental health practitioners and social workers into GP practices was announced for two counties in NI, namely Derry and Down. It has been described by the Department of Health as the first stage in a £15m transformation of GP care in Northern Ireland with recruitment for an estimated 200 posts expected to being shortly.

It is hoped the initiative will highlight opportunities for early intervention and lead to a reduction in the numbers of GP referrals to services outside of the practice.

The initiative is part of the Bengoa plan to transform health and social care in NI, as described in Chapter 2 (Heath and Wellbeing, DoH, 2026). Although this is certainly positive news, there is ambiguity with regards to the ‘mental health practitioners’, in that it has not been specified what kind of practitioner this will be. If services were to be modelled on IAPT, and moreover the NICE evidence base, then these practitioners should be PWPs; the need for more low intensity practitioners in NI in

order to facilitate a functioning and cost effective stepped care model has been highlighted (Blane et al., 2014; HSC, 2014).

5.4 Implications

It has been reported that the retention of high intensity therapists within IAPT services is generally good, but that there has been some difficulties in relation to the retention of PWPs (NCCMH, 2018). This is possibly due in part, to the fact that a large proportion of PWPs progress to high intensity training after relatively short periods working in their low intensity role.

Although it is promising that such well trained and clinically skilled practitioners demonstrate commitment to their profession, it is considered more difficult to maintain certain national standards if qualified therapists do not retain a position for long enough following initial training (NCCMH, 2018). This is something which should be considered as we contemplate how to improve access to low intensity services for people in NI. There is an urgent need to expand the number of PWPs being trained here, and to ensure that there are an adequate number of services throughout the province from which they can operate. This highlights once again why they should be the practitioners employed with regards to the aforementioned pilot initiative shortly to be launched within some NI GP practices.

IAPT services have outlined useful standards of good practice in relation to the retention of the PWP workforce. Firstly they have highlighted that the value of PWPs should be recognised and that they should be fully integrated into a stepped care team. In terms of NI, this reinforces the need to promote the role and to increase awareness of the purpose of the role to service providers and to the general public. (NCCMH, 2018).

5.4.1 Improving access: best practice

There are several ways in which IAPT service commissioners and providers can work in order to further improve access. Firstly it is important to improve the identification of common MH difficulties. Depression and anxiety disorders are frequently undetected and undiagnosed by GPs and other professionals. Identification rates can be increased however by increasing MH awareness and reducing stigma. Furthermore there should be increased focus on recognising MH problems (NCCMH, 2018).

NICE guidelines stipulate that all healthcare professionals should be aware of potential symptoms of depression or anxiety and consider the use of a screening tool where relevant (IAPT, 2008). It has also been recommended that education and training on MH problems are delivered to multidisciplinary teams within physical care pathways working within IAPT-LTC-MUS services.

It is important to increase awareness of IAPT services and promote self-referrals. It is imperative that professionals and the general public have clear and accessible information regarding how local services can be accessed and what treatments they can avail of. This is something in turn which can further promote the use of self-referral options (Gyani et al., 2013). More specifically it has been suggested that services can be promoted using clear concise and engaging materials which should be distributed in GP practices, job centres and other community and public places. Services should also have clear websites which are easy to navigate and fully describe the services they provide. Links must also be maintained with local and third party organisations such as housing services, financial support, employment support, citizen's advice and charitable organisations who work with minority

groups (NCCMH, 2018). NHS England are also currently working with NICE to develop a new digitally – enabled therapy assessment programme which will facilitate treatment access anywhere at any time and can reduce the stigma associated with help seeking for MH problems (NCCMH, 2018)

5.4.2 Good service organisation

Analyses of national IAPT data has identified several characteristics of services which influence clinical outcomes. Services with higher rates of accurate problem descriptors obtain more positive treatment outcomes, as do those with a higher average number of sessions, and with lower rates of missed appointments. In relation to waiting times, services that have a shorter period between assessment and the beginning of treatment achieve more positive outcomes, possibly because people become more reluctant to engage with services after a long wait (Gyani et al., 2013, NCCMH, 2018). It has also been determined that service located in socially deprived areas are more likely to have poorer outcomes, although services in such areas still still meet IAPT national standards. This highlights the importance of providing adequate access to high quality services in socially deprived areas.

5.4.3 Commissioning

In England, the point is continually emphasised that all IAPT services must be adequately staffed in order to provide the correct NICE recommended treatment at the right dose (Clark et al., 2009). Our challenge in NI is to commission a correctly structured stepped care system which is adequately staffed and funded.

5.4.4 Modifying interventions for specific populations

When considering how to improve access for specific patient populations and underrepresented/minority groups, several factors should be regarded. Firstly,

facilitating services in a variety of venues including community centres and job centres, and even people's homes can increase the likelihood of access and engagement for many. As discussed earlier, this can be enhanced by ensuring people have the option of self-referring (Clark et al., 2009; Gyani et al. 2013). Increasing awareness of the purpose of services and providing a clear overview of referral options and pathways is also critical in relation to expanding access.

It is also important that the content of intervention resources and the length of treatment sessions can be modified according to the needs of the patient; for example this could mean scheduling longer sessions to account for the use of an interpreter, or using more visually-based materials throughout treatment for people with literacy difficulties. Importantly LICBT interventions can also be delivered over the telephone or through the use of technology; it is an important responsibility of the service provider to ensure that patients are given a choice in relation to how evidence based interventions are delivered (Clark et al., 2009; Richards & Whyte, 2011).

5.4.5 Personal reflections of researcher

As discussed in the reflexivity section, as a PWP myself, I must acknowledge that I approached the research question and the interviews while holding some assumptions, hopes and personal beliefs regarding what the outcomes should or might indeed be. I believe passionately in the effectiveness of this service and endorse the view that improving access to these early interventions does indeed represent a revolution in the provision of mental health care, as it has been described in England. In NI, we are in a unique yet unfortunate position, given that we have no stable government nor do we have a commissioned and functioning stepped care model to facilitate service delivery. I was aware of this before, but these difficulties

and challenges have been clearly highlighted by interviewees also, and to a greater extent than I had anticipated. My question before undertaking this qualitative research remains unanswered i.e is a service clinically effective if it is not adequately available? We must continue to ensure that availability and the other concepts related to access are realised. The service works, and everyone who might benefit should be able to access it. We are not there yet.

5.5 Future research

As indicated in throughout the thesis thus far, we do not yet have a service framework in NI which formally applies NICE evidence, and specifically with regards to the widespread implementation of low intensity services as per a stepped care framework. The effective use of research evidence can help policy makers establish a “judicious application of the best current knowledge” (Sackett et al., 1996, p.71). Achieving this standard can be problematic for a number of reasons. For example, it has been suggested that translating research findings into a local population context can be challenging due to the complex nature of healthcare needs within local communities (Marmot et al., 2010). However, the IAPT initiative can again be looked at as a successful example of a programme which has substantially improved appropriate service access through the use of clear guidelines, clear training and supervisory procedures, and tool standardisation (McHugh & Barlow, 2010).

It is important to consider how we might learn from this when considering how to implement a service modelled on IAPT in NI. Considering how to implement an effective service locally requires much more than dissemination of evidence and training a new workforce (Grimshaw, Eccles, Lavis, Hill & Squires, 2012; May &

Finch, 2009; Steen, 2015). It is important to consider individual attitudes and expertise, financial and budgetary limits, and sociocultural factors (Damschroder et al., 2009), all of which have been reflected in the themes uncovered here. The IAPT programme reports high levels of attrition and dropout and considerable variability in access and recovery rates which further highlights the importance of understanding appropriate implementation in the context of local populations. An adequate understanding of implementation processes is considered increasingly important to facilitate effective application of evidence based interventions (Eccles et al., 2009; McHugh & Barlow, 2012). Therefore, as we seek to develop and increase the capacity of a PWP service model in NI, we should continue to monitor and evaluate services in order to inform future service modifications and best practice.

The PWP service was determined as working effectively within a SP project as per findings from the current evaluation. A recent study (Loftus, McCauley & McCarron 2017), examined outcomes relating to the use of a pilot SP project in a GP practice in NI. They found that those clients who had depression and anxiety were less likely to engage in SP, and moreover found that it did not reduce the frequency of GP visits or polypharmacy for those with chronic conditions. This was contradictory to other research which determined that frequent GP attenders who had participated in CBT halved the frequency of their GP visits (Malins et al., 2016).

Given research evidence to date, and indeed the findings from this qualitative study, it would be reasonable to assume that patients with clinically relevant depression and anxiety symptoms may be more likely to engage with SP if mental health difficulties could be addressed before or even alongside social prescribing activities. Future research could therefore evaluate the effectiveness of PWPs working as both mental health practitioners and social prescribers within a GP practice. The need for more

research in relation to SP has been highlighted by a recent UK based systemic review which concluded there is insufficient evidence on what approaches work for whom and in what circumstances (Lovell et al., 2017). The authors furthermore recommended that all SP programmes should have a process of evaluation.

A final future research recommendation relates to exploring the perspectives of those who have used the NI PWP service. Positive client feedback was referred to by many of the service facilitators interviewed in the current evaluation. As indicated earlier, client feedback is considered to be essential in regard to informing service reform (Coulter, Locock, Ziebrand & Calabrese, 2014; NHS, 2013). Many IAPT services have reported high levels of client satisfaction, however these are frequently deduced from quantitative scales and measures as opposed to actual qualitative feedback (Clark et al., 2009; Kuhn, 2011), even though client input in terms of planning and service advocacy is recognised as highly important (Baddeley, 2014; Hamilton et al., 2011; Steen, 2015). Qualitative findings to date have been quite inconsistent and clarify a need for further evaluations of this kind (Campbell, 2013; Steen, 2015). Services must be responsive to patients' needs and to communicate with them regarding problems around attending and engaging.

Learning more about such difficulties represents an opportunity for services to engage with the individual, as well as an opportunity to learn more about how best to deliver psychological therapy for those in need.

5.6 Limitations

The fairly small and selective sample used in the current study place limits on how representative the data is. However, this does follow the recommendations of Smith

et al. (2013) that such purposively selected small samples enhances the depth of data by concentrating on quality over quantity.

Issues with the applicability and accuracy of self-reporting data must also be acknowledged given the potential impact of bias associated with socially desirable narratives. However, this was mitigated by reassurances of anonymity as detailed on the study information sheets and participant consent forms.

It is important acknowledge the limited nature of the data in the current study and consequently there are limits in relation to the empirical generalisability of the outcomes. (Smith et al. (2013) however, also emphasise the importance of theoretical transferability; IPA is helpful given its focus on individual experiences, something not frequently highlighted by other methodologies.

The use of semi-structured interviewing is also a potential limitation; although the questions remain open –ended, they are also formulated in order to focus narratives on phenomena relevant to the research objectives. It may be argued that emergent themes are determined as a result of this as opposed to representing a true reflection of unique individual experience. However it was necessary to remain focused on addressing the particular research questions and interview questions were broad.

It has been suggested that it is impossible to completely remove oneself and personal thoughts and beliefs about the world from the research process (Larkin et al., 2006). Acknowledging the role of the researcher as indicated in the previously described reflexivity section is beneficial, as it does not ignore their potential influence. It is important to acknowledge the researcher's (in this case my own) interpretations of and feelings about the interviews conducted and the resultant data gathered, given the subjectivity associated with qualitative analyses.

It must also be acknowledged that only one researcher analysed this data, increasing the possibility that certain themes or sub themes may not have been recognised, and interpretation is more restricted.

The potential limitations outlined here do not invalidate the outcomes however it is important to acknowledge them alongside the conclusions and resultant implications of this qualitative research. The objective of this investigation is to provide in depth data in order to inform and reflect upon how effective the PWP service has been and can be in NI.

5.7 Conclusion

The current findings may be described as being representative of a balanced view in regards to the PWP service model in NI. Whilst it has been described as clinically effective and something which fills a gap in service provision, conversely, problems around lack of awareness, and lack of availability were highlighted. In relation to the reflections about general mental health services in NI, a plethora of problems and barriers to treatment access, both attitudinal and systemic were strongly represented in the data. Although some reflections were made in relation to hope for positive future change, this was conveyed by only half of the sample, and it seems NI is far from implementing a functioning stepped care model at the moment. We have established that the PWP service is clinically effective in a NI context.

However, we need to increase awareness, and can we reasonably increase awareness without increasing availability? Moreover, we cannot increase utilization without increasing availability. How truly effective is the PWP service if access remains inadequate? The potential effectiveness of a fully implemented and sufficiently

staffed PWP service is clear, and this must be realised in order for all of those with common mental health difficulties in NI to benefit. Equality and fairness are the core values upon which the NHS was founded, and every person has an equal right to access, be treated by, and benefit from NHS services. No person or group is exempt from common mental health difficulties and so the demand for evidence based therapies is high within all communities. It is essential that commissioners and service providers understand the prevalence of depression and anxiety disorders within their own local populations in order to facilitate better access to services (IAPT, 2008). Policy makers within the Department of Health in NI could benefit from the outcomes of this study, in particular when considering the newly established mental health practitioner roles in GP practices. If PWPs were to take up these posts, it would go a long way to addressing the issues highlighted.

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Chapter 6

Expanding services for medically unexplained symptoms (MUS): A service needs analysis investigating the prevalence of non-cardiac chest pain (NCCP) using Emergency Department (ED) data in NI.

A brief version of this chapter has been published in BMC Health Services Research:

McDevitt-Petrovic, O., Kirby, K., & Shevlin, M. (2017). The prevalence of non-cardiac chest pain (NCCP) using emergency department (ED) data: a Northern Ireland based study. *BMC health services research*, 17(1), 549.

What next for PWPs in NI?

Thus far, this project has focused specifically on evaluating the new PWP service model in NI. The outcomes in Chapters 3 -5, indicate that the service is clinically effective, and is appreciated as a valuable resource for accessing timely and appropriate interventions, although more work is required in order to ensure it is adequately available and utilised. The PWPs in NI, specifically treat those who have presented with mild to moderate level depression and anxiety disorders. However, within the English IAPT initiative, the PWP workforce also effectively help individuals with other associated conditions, and importantly, PWP services there are accessible to individuals who may not access services through their GP or through a community or voluntary site. Since 2018, all IAPT services are required to offer care for those with long term physical conditions and/or medically unexplained

physical symptoms. It would be useful for us to consider if there are other sub populations of patients in NI, who might benefit from the PWP service, and who cannot access it according to how it is currently set up. In order to begin exploring this, a needs analysis was carried out, specifically investigating the prevalence of a medically unexplained symptom which is frequently associated with anxiety, specifically non-cardiac chest pain. If a need has been established, might it be feasible to also evaluate the effectiveness of PWPs in this context? The focus therefore of the final two empirical chapters is an exploration of where else PWPs might fit, through establishing need within a specific sub population, and subsequently a review of interventions to support the case (or not) for using PWPs.

Chapter Overview

As outlined in Chapter 1, the English IAPT initiative is currently focused on developing services for individuals with mental health difficulties who also have MUS or LTCs. A recently published document by NHS England ‘Implementing the Five Year Forward View for Mental Health’ (NHS, 2016) outlines a commitment to achieve parity of esteem for mental and physical health. It is expected that by 2020/21, an additional 600,000 individuals will access IAPT services in England, and that two thirds of these will have coexisting physical health problems. The purpose of the current chapter is to begin investigating if such service developments may also be usefully implemented in NI.

More specifically, as indicated in previous chapters, we now have preliminary evidence that a PWP service (LICBT) delivered according to IAPT model specifications, is clinically effective for individuals with mild to moderate level depression and anxiety in NI. This chapter will examine the prevalence of a common

medically unexplained symptom (specifically non-cardiac chest pain), in order to determine if there is a need for improved access to psychological therapies for such patient populations in NI. This investigation was initiated at the request of cardiologists and subsequently the Health Improvement Department within a large urban hospital in North West Ireland; physicians noticed a marked increase in the number of patients attending cardiac clinics, where there was no physical explanation for symptoms. An urgent need to establish the extent of this issue was therefore highlighted, with a view to proposing a course of action.

6.1. Introduction

6.1.1 Chest pain as a medically unexplained symptom.

Chest pain is a common complaint which is frequently non-cardiac in origin. Research to date indicates that between 52% and 77% of patients who present to an ED with chest pain are discharged without clear medical diagnosis, and thereby may be referred to as incidences of unexplained chest pain (UCP), or non-cardiac chest pain (NCCP) (Christenson et al., 2004; Dunville, MacPherson, Griffith, Miles & Lewin, 2007; Stallone et al., 2014). A recent review of clinical care posited that the focus of care is more often on the exclusion of coronary disease and medical diagnosis, and not on the appropriate management of NCCP, despite the substantial prevalence rates (Chambers, Marks & Hunter, 2015). Consequently, patients with NCCP frequently endure chronic symptoms in addition to high levels of psychological distress (Chambers, Marks, Kinsley & Hunter 2013; Marks, Chambers, Russell, Bryan & Hunter, 2014).

Moreover, several studies have identified UCP and/or NCCP as a significant public health concern, linked with increased limitation of daily activities, work

absenteeism, unemployment, disability, and repeated attendance at emergency departments, primary care, and acute medical services (Christoph et al., 2014; Eslick & Talley, 2004; Fagring et al., 2008; Jerlock et al., 2008).

6.1.2 Frequent and inappropriate use of healthcare services

Frequent users represent 21% to 28% of all visits to the ED where frequent is defined as four or more visits in a year (LaCalle & Rabin, 2010). Chest pain has been found to account for 21% of primary presentations from 1200 visits (Milbrett & Halm, 2009). However, strategies to redirect patients from emergency care are often rejected, given that many visits are considered necessary based on the presenting symptoms (LaCalle & Rabin, 2010). ‘Inappropriate’ attendances although difficult to precisely establish in all cases, are estimated to represent up to 40% of all ED visits (LaCalle & Rabin, 2010).

In the U.S., costs for the initial care for UCP has been estimated at eight billion dollars. However, not enough is known about the long term economic consequences of NCCP (Eslick & Talley, 2004). Despite reassurance by physicians, more than 50% of NCCP patients continue to report symptoms (Beek et al., 2013). A high prevalence (44%) of panic-like anxiety has been detected among NCCP patients in ED, with panic being diagnosed by emergency physicians in just 7.4% of these cases (Folds-Busque et al., 2011).

6.1.3 The role of anxiety in NCCP

Anxiety is said to have a key role in the neuro-behavioural processes associated with pain regulation, possibly contributing to UCP/NCCP. Some of the autonomic symptoms of anxiety are also features of NCCP, which may somewhat explain the findings of Smeijers et al. (2013), who detected higher levels of anxiety among

individuals with NCCP compared with healthy individuals. This is also consistent with previous works which have indicated that the prevalence of panic disorder in NCCP is considerably higher than in the general population (Barlow, 2002; Huffman & Pollack, 2003). Furthermore, White et al. (2008) outlined a number of other psychological factors which are commonly comorbid with both panic disorder and NCCP, namely mood disorders, personality traits, and anxiety disorders other than panic.

Regarding respiratory symptoms being masked by anxiety, it is also useful to acknowledge that chest pain is not the only somatic symptom associated with anxiety. A number of studies have pointed to a link between panic disorder and a hypersensitivity to carbon dioxide (Papp et al., 2015), and between anxiety and reported respiratory sensations (Von Leupoldt, Chan, Bradley, Lang & Davenport, 2011). Pfortmueller et al. (2015) aimed to characterise patients with a primary presenting complaint of hyperventilation in the ED where a physical diagnosis was absent; a third of this identified population had previously experienced an episode of hyperventilation, and 50% had psychiatric comorbidity. Pfortmueller et al. (2015), have advocated the need for further studies investigating the prevalence of primary hyperventilation within acute medical services, given the lack of existing literature in this field.

Furthermore, anxiety and depression have been found to occur with similar prevalence rates among individuals with an actual cardiac disease diagnosis, and those identified as presenting with NCCP (Chambers et al., 2015). Importantly however, research indicates that these psychological difficulties are much less inclined to be resolved in NCCP (Chambers et al., 2014; Clare, Andiappan, MacNeil, Bunton & Jarrett, 2013; Robertson, Javed, Simani & Khunti, 2008), and are also

associated with more health related cognitive distortions (Marks et al., 2014). More specifically, panic disorder is the psychological difficulty most prevalent among individuals with NCCP (Huffman & Pollack, 2003). As previously mentioned this is thought to be associated with the similarities between particular cardiovascular symptoms and the inclination of those with panic disorder to focus on the autonomic symptoms they perceive as dangerous (Barlow, 2002; Lessard et al., 2012). Despite reassurance by emergency physicians and cardiologists, more than 50% of patients presenting with NCCP continue to report chest discomfort and remain worried they have a serious health condition or have suffered myocardial infarction (Beek et al., 2013).

Foldes-Busques et al. (2010) also determined a high prevalence (44%) of panic-like anxiety in ED presentations, using valid psychometric tools including the State-Trait Anxiety Inventory (STAI) and the Anxiety Sensibility Index (ASI). However, this study also determined that physicians in the ED diagnosed just 7.4% of these panic cases. In addition to this, studies have also determined that even where panic and anxiety are identified in the emergency department, the appropriate interventions are seldom initiated within the scope of these services (Dammen, Bringager, Arnesen, Ekberg & Friis, 2006; Wulsin et al., 2002). Based on their findings, Foldes-Busques et al. (2010) have suggested that the need to increase understanding of unexplained chest pain in emergency departments is critical, and thus improved access to the appropriate psychological interventions could reduce attendance at health services and limit the social, physical, and occupational costs associated with anxiety and panic disorders.

6.1.4 Aims

Evidence has shown that a significant proportion of admissions to the ED presenting with chest pains will result in a diagnosis of NCCP, however there is scarce data on the frequency of presenting and diagnoses in the U.K. Based on the recommendations of existing research, and following the requests of physicians in a UK hospital, it was considered important to assess the frequency of NCCP cases presenting in ED departments in Northern Ireland, as to date no such studies have been carried out. The outcome of such a study would support the need (or not as the case may be) to provide additional psychological services for people who are repeatedly using hospital services for NCCP with possible associated anxiety or panic disorders. The primary aim of this study aimed was to use administrative data to assess the number of chest pain admissions to an ED department and the subsequent counts of NCCP over a 3 year period. The likelihood of NCCP based on admission with chest pain was estimated.

6.2 Method

6.2.1 Study Design and data access

This study used administrative data from an urban district general hospital in the North West of Northern Ireland. Records relating to initial presentation and subsequent diagnosis for 3 years were analysed. With the permission of service managers within Clinical Governance and the Western Trust Service Improvement Department, records for all patients attending the ED between March 2013 and March 2016 (N = 180, 409) were accessed by Trust administrative staff. All entries were anonymised. Data for each year was examined in order to 1) assess the frequency of attending the ED with chest pain or heart problems, 2) assess the frequency of diagnoses related to NCCP, anxiety and panic, and 3) to estimate the

relationship between presenting with chest/heart related problems and a subsequent diagnosis of NCCP or anxiety.

6.2.2 Data management and analysis procedures

The following strategies were implemented in order to estimate the frequency of attending the ED with chest pain and heart problems, and to calculate the counts of diagnoses related to NCCP, anxiety and panic.

Stage 1: There was no standardised format for recording specific presenting problem. The research team initially reviewed the entries for each year to identify potential ways in which ‘heart related’ problems were recorded. A systematic review of the entries revealed that the most common descriptors were ‘chest pain’, ‘palpitation (s)’, ‘heart’, and ‘chest tightness’. These were subsequently used as search terms to identify those attending ED with ‘heart related problems’.

Stage 2: There was no standardised format for recording diagnoses. A systematic review of entries identified the most common descriptor of non-cardiac diagnosis to be ‘chest pain of unknown cause.’ Three columns were created for diagnoses, with ‘anxiety’, ‘panic’ and ‘chest pain of unknown cause’ coded as 1, and all other ‘non’ cases within these were coded as 0.

Stage 3: Frequencies and percentages of chest pain presentations and specific non-cardiac diagnosis for each year (2013/14, 2014/15, and 2015/16) were calculated (see Table 1), in addition to frequencies and percentages of chest pain presentations and specific non-cardiac diagnosis and any non-cardiac diagnosis for all years combined (see Tables 2 and 3). Chi-square tests were carried out in order to estimate the degree of association of non-cardiac diagnoses and all other diagnoses within chest pain presentations across the total sample (see Tables 1 and 2).

Stage 4: For the purposes of inter-rater reliability, a second researcher also completed a systematic review of entries as outlined in stages one and two. The identified terms were then used and subsequently the second researcher determined the same frequencies as the first researcher. The results obtained were therefore identical for both researchers.

6.2.3 Ethics

This study was approved by clinical research governance the WHSCT as a needs analysis study; the data was fully anonymised (no personal identifying features remained), and data was on a secured and password protected device.

6.3 Results

Table 6.1 shows that there was an annual increase in the overall number of ED attendances during the period 2013 to 2016, increasing from 59,244 to 63,122. There was a corresponding increase in the frequency of patients presenting with chest pain (4.1 to 5.1%) over the same period, and chest pain presentations with a subsequent diagnosis of unknown cause similarly increased year on year. The most common non-cardiac diagnosis each year was ‘Chest pain of unknown cause’ (33.8 - 40.2%), with a relatively small number of diagnoses of ‘anxiety’ (1.3 - 2.4%) or ‘panic’ (.5 - .75%). Table 6.2 shows that when all 3 years were combined 8295 (4.6%) of initial presentations were chest pain, and 135 (24.4%) and 54 (24.5%) were anxiety and panic diagnoses respectively following an initial presentation of chest pain. Over half (n = 3156, 64%) of diagnoses indicating ‘chest pain of unknown cause’ followed an initial presentation of chest pain. The chi-square tests showed that presenting with chest pains and receiving a diagnosis of panic, anxiety, or CPUC were significantly associated. In total, 3345 (58.7%) of all the non-cardiac diagnoses (anxiety, panic

and chest pain of unknown cause) followed an initial presentation with chest pain, and this association was statistically significant ($\chi^2 (1) = 39,263.76, p < .001$)

Table 6.1.Frequencies and percentages of chest pain presentations and specific non-cardiac diagnosis for each year (2013/14, 2014/15, and 2015/16)

Chest pain presentations and corresponding diagnoses				Year(s)		Total	
				2013/14 (N= 59,244)	2014/15 (N=58,123)	2015/16 (N=63,122)	2013-2016 (N=180, 489)
Presenting with chest pain	Yes	N	2381	2675	3239	8295	
		%	4.1%	4.6%	5.1%	4.6%	
	No	N	56,863	55,448	59,883	172194	
		%	95.9%	95.4%	94.9%	95.4%	
				Presenting with chest pain 2013/14 (N= 2, 381)	Presenting with chest pain 2014/15 (N= 2, 675)	Presenting with chest pain 2015/16 (N= 3, 239)	Presenting with chest pain 2013-2016 (N= 8, 295)
Diagnosis of ‘anxiety’ within chest pain presentations	Yes	N	56	34	45	135	
		%	2.4%	1.3%	1.4%	1.6%	
	No	N	2325	2641	3194	8160	
		%	97.6%	97.7%	98.6%	98.4%	
Diagnosis of ‘panic’ within chest pain presentations	Yes	N	13	20	21	54	
		%	0.5%	0.75%	0.6%	0.6%	
	No	N	2368	2655	3218	180435	
		%	99.5%	99.25%	99.4%	99.4%	
Diagnosis ‘Chest pain of unknown cause’ within chest pain presentations	Yes	N	804	1049	1303	3156	
		%	33.8%	39.2%	40.2%	38%	
	No	N	1577	1626	1936	5139	
		%	66.2%	60.8%	59.8%	62%	

Table 6.2 Frequencies and percentages of chest pain presentation and specific diagnoses for all years

			Diagnosis						Total	Diagnosis	
			No Anxiety (N=179902)	Anxiety (N=551)	No Panic (N=180223)	Panic (N=220)	No CPUC (N=175525)	CPUC (N=4929)		All other Diagnoses (N=174753)	*Any Non- Cardiac Diagnosis (N=5700)
Presenting with chest pain	Yes	N	8160	135	8241	54	5139	3156	8295	4950	3345
		%	4.5%	24.5%	4.6%	24.5%	2.9%	64%	4.6%	2.8%	58.7%
	No	N	171742	416	171992	166	170386	1773	172158	169803	2355
		%	95.5%	75.5%	95.4%	75.5%	97.1%	36%	95.4%	97.2%	41.3%
			$\chi^2(1)=499.29, p <.001$		$\chi^2(1)=199.88, p <.001$		$\chi^2(1)=40815.10, p <.001$		$\chi^2(1)=39263.76, p <.001$		

Note: CPUC = Chest pain of unknown cause *Indicates all cases discharged with anxiety, panic or CPUC

6.4 Discussion

The findings from this study are consistent with those in the current literature (Stallone et al., 2014) given that a large proportion of patients presenting at ED with ‘chest pains’ were subsequently given a non-cardiac diagnosis: anxiety (1.6%), panic (0.6%), or NCCP (38%). This pattern of results was consistent over the three years of this study. Little is known about the long term economic costs of NCCP, however studies to date have highlighted that costs to services are likely to be substantial (Eslick & Talley, 2004). NCCP patients have been found to use out-patient services to the same extent as those who have cardiac diagnosis (Beek et al., 2013). Although less is known about the indirect costs, a recent longitudinal study concluded that both the direct healthcare, and cumulative societal costs of NCCP are considerable (Mourad, Alwin, Stromberg & Jaarsma, 2013).

6.4.1 What is the prognosis for patients with NCCP?

Patients presenting with chest pain where heart disease has been ruled out, have a good prognosis medically, and the risk of future cardiac morbidity is the same as the general population (Cannon 2009). Although the prognosis may not be concerning in medical terms, it has been determined that NCCP patients do not function particularly well. Shah, Kataria and Tanna, (2015) evaluated and subsequently reported significant degrees of anxiety and depressive symptomatology among patients attending an outpatient service following their first episode of UCP. They found UCP was persistent, causing long term physical limitations and negatively impacting routine daily life. More specifically, they reported chest pain to be persistent in 50-70% of UCP patients, and determined loss of employment in 19-51% of the group, with functional loss reported in between 40 and 100%.

Furthermore, Schwarz, Prashad and Winchester, (2015) suggest that anxiety is extremely prevalent, and insufficiently recognised and managed within emergency care settings. A number of possible reasons have been suggested for this, including a lack of access to validated screening tools, and the hesitation of physicians to enquire, given that patients can be defensive about potential psychological causes (Hocaoglu, Gulec & Durmus, 2008). Foldes-Busques et al. (2010) also determined a high prevalence (44%) of panic-like anxiety in ED presentations and subsequently determined that physicians in the ED diagnosed just 7.4% of these panic cases. Based on the findings of the current study it may be tentatively suggested that anxiety may not have been picked up as it may not have been screened or assessed for after a cardiac diagnosis has been ruled out. Therefore, a future clinical and research recommendation could be to initiate a pilot study to screen for anxiety in all those who are given an outcome of 'chest pain of unknown cause' or be referred to an appropriate professional for a brief clinical assessment, with a view to treatment. Research has also suggested that even where panic and anxiety are recognised within the emergency care services, the appropriate interventions are seldom initiated here (Dammen et al., 2006; Wulsin et al., 2002).

Many patients with unexplained chest pain, never discover a known cause for their physical pain (Bozkurt Zincair et al., 2014). More specifically Bozkurt Zincair et al. (2014) found anxiety, somatic symptoms and the magnification of bodily sensations to be highly prevalent among NCCP patients, and concluded that they needlessly attended cardiology outpatient services.

6.4.2 Interventions

Current reviews of clinical care have highlighted a failure to appropriately manage NCCP despite the substantial prevalence rates (Chambers et al., 2015). Studies to date have pointed to the efficacy of cognitive behavioural therapy (Spinhoven, Vender Does, Van Dijk & Van Rood, 2010; Marchand et al., 2012). The efficacy of cognitive behavioural therapy as an intervention for NCCP has been evaluated in a number of randomised controlled trials (George, Abdallah, Maradey-Romero, Gerson & Fass, 2016). Mayou et al. (1997) compared CBT and standard clinical advice among NCCP patients and found major reductions in both the frequency and severity of symptoms in the CBT group, and only modest improvements within the control group.

Similarly Spinhoven et al. (2010) conducted an RCT with UCP patients and found that those who had completed a course of CBT had a significantly higher treatment response when compared with placebo and medication groups. Keefe et al. (2011) found that a low intensity CBT intervention, more specifically “coping skills” resulted in significant improvement relating to the catastrophizing of pain symptoms and anxiety when compared to a placebo group.

Recent research has also emphasised the success of brief cognitive behavioural therapy; Johson, Martinsen, Morken, Moum, and Dammen, (2013) found a three session CBT intervention to be effective for UCP patients in terms of illness perception. Beek et al. (2013) concluded that a brief cognitive behavioural intervention significantly reduced levels of anxiety and depression in patients with NCCP, with a diagnosis of panic and/or a depressive disorder based on HADS (Hospital anxiety and depression scale) scores.

Based on these findings, Beek et al. (2013) recommended that individuals presenting with NCCP should be assessed for psychopathology, and a cognitive behavioural intervention offered in cases where psychological difficulties are detected. Lessard et al. (2012) found that cognitive behavioural interventions as brief as even a single session initiated within two weeks of an emergency attendance for the primary complaint of chest pain, seem to be effective for panic disorder. Furthermore, they have recommended that increased efforts should be employed to implement these interventions in the emergency department/primary care setting, considering the high prevalence of panic disorder there.

Several studies have now pointed to the fact that UCP patients frequently endure chronic symptoms and high levels of psychological distress (Chambers et al., 2013; Marks et al., 2014). Given the high percentage of patients in the current study who were discharged with an outcome of “chest pain of unknown cause”, future work is needed to assess the degree and prevalence of anxiety disorders among this group here in Northern Ireland. Furthermore, given the evidence base for the efficacy of CBT within this patient population, it may be posited that future research is also warranted to evaluate the effectiveness of a CBT intervention for those patients identified as having UCP and associated significant anxiety.

As highlighted previously, it is also important to acknowledge that chest pain is not the only somatic symptom associated with anxiety; several studies have reported on the association between anxiety and respiratory sensations such as shortness of breath (Papp et al., 2015; Pfortmueller et al., (2015). Moreover they have advocated the need for further research in this particular field, given the current lack of existing literature.

It would be useful for future studies to assess anxiety and health anxiety symptomatology among UCP patients in order to obtain accurate knowledge regarding the prevalence of psychological distress among this patient population.

6.4.3 Economic implications

NCCP patients have been found to use out-patient services to the same extent as those who have cardiac diagnosis (Beek et al., 2013). Although less is known about the indirect costs, a recent longitudinal study concluded that both the direct healthcare, and cumulative societal costs of NCCP are considerable (Mourad et al., 2013). Governments are increasingly recognising the long term economic and social costs of high prevalence disorders including common mental health difficulties such as anxiety and panic disorder. Low intensity cognitive behavioural therapy is the most strongly evidenced in relation to common anxiety disorders, and moreover it has been shown to save money in the long term (Layard and Clark, 2014). It is still the case however, that we do not have the care pathways in place which apply the evidence in order to facilitate the provision of timely and appropriate interventions. As highlighted previously, NCCP has been identified as a significant public health concern given the associations determined between unemployment, disability, reduced function and repeated use of services (Christoph et al., 2014; Eslick & Talley 2004; Fagring et al., 2008; Jerlock et al., 2008).

6.4.4 Limitations

It is important to note that the data used to obtain frequencies in the current study was fully anonymised and indicated only primary presenting problem and the subsequent diagnosis. It was not possible to determine if the same individual had attended services with the same or a similar presentation more than once.

This is an acknowledged limitation of the current study but it can also be a future research recommendation to attempt to track repeat attenders who were discharged with NCCP. The non-standardised format of recording presenting problems was also a limitation. However, a thorough systematic review of entries was conducted and inter-rater reliability was established. It is also important to acknowledge the limitations relating to generalizability, given that the data pertains to a single emergency department.

6.4.5 Practical research and clinical recommendations

This study has determined that there is a significant incidence of patients attending the ED with UCP/NCCP. The findings were subsequently discussed with the service improvement department, the clinical health psychology department and relevant staff and consultants in the ED, during which a number of key practical and clinical research recommendation were made.

In order to improve the recording of patient data on the Symphony database, it would be useful to implement a standardised system to record presentations and outcomes, such as a drop down menu.

Given the link between NCCP and frequent and inappropriate use of services, and the costs to healthcare systems, the degree of repeat attendance should be investigated. Therefore a system within the database which allows for easier identification of repeat NCCP attenders would be useful.

There is a need to determine what the current communication and referral pathways are for individuals with NCCP, and to actually assess and determine the views and experiences of individuals who are NCCP repeat attenders.

The association between UCP/NCCP and clinical anxiety warrants further exploration, more specifically in relation to the prevalence of anxiety among this patient population, and the development of appropriate and timely psychological interventions.

A more detailed psychosocial and medical profile of those who repeatedly attend emergency services with non-cardiac chest pain, would help in identifying other potentially significant associated factors.

Future research may take the form of a randomised control trial facilitating the piloting of an intervention. The first element would provide NCCP patients with some type of psychoeducational material regarding the nature of anxiety symptoms. The second element would involve setting up a referral pathway from emergency department staff to the GP. The GP would the subsequently refer to the psychological therapies hub from which onward referral to the appropriate service would be made. Psychological wellbeing practitioners would likely form part of this referral pathway given the evidence base for the efficacy of low intensity CBT for health anxiety.

Useful future research could also take the form of a systematic review in order to explore which interventions including those of a brief and low intensity may or may be efficacious in the treatment of NCCP, other medically unexplained symptoms and associated health anxiety.

A final recommendation relates to the provision of additional training for emergency department staff particularly in relation to accurately identifying these individuals and how to subsequently refer them to an appropriate service.

6.5 Conclusion

This study has shown that there is a significant percentage of patients attending the ED with NCCP. Given the link between NCCP and frequent and inappropriate use of services, and the costs to healthcare systems, the degree of repeat attendance should be investigated. Furthermore, the association between NCCP and clinical anxiety warrants further exploration, more specifically in relation to the prevalence of anxiety among this patient population, and the development of appropriate and timely psychological interventions.

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Chapter 7

Systematic review: assessing the effectiveness of brief and low intensity psychological interventions for medically unexplained symptoms/somatic symptom disorder, non-cardiac chest pain, and illness anxiety disorder/health anxiety.

Chapter Overview

In keeping with research recommendations outlined in Chapter 6, the objective of the current chapter was to conduct a systematic review to assess the effectiveness of brief psychological interventions for medically unexplained symptoms/somatic symptom disorder, non-cardiac chest pain, and illness anxiety disorder/health anxiety. Google Scholar, PubMed, and Web of Science were searched as data sources. Reference lists were subsequently examined for other relevant articles. Studies were assessed according to specified inclusion criteria and extracted according to PRISMA guidelines. A total of 23 studies were included in the final synthesis. Significant effects for intervention groups relative to control groups were reported in 19 studies, whilst 4 studies did not determine any significant benefits of interventions compared with controls. All of the brief interventions (CBT, psychosocial, psychophysiological, psychosomatic, relaxation and group therapy), with the exception of metaphor therapy, showed significant effects relative to controls in at least one study. The evidence suggests that brief psychological interventions, more specifically time limited CBT based interventions may be effective in treating HA and MUS with psychological distress. Findings are comparable with other reviews. Future research may facilitate the piloting of an

intervention, and there remains a need to provide more robust evidence of cost effectiveness.

1. Introduction

1.1 Definitions, diagnostic criteria and comorbidities

There has been considerable dispute around the classification and terminologies used in relation to medically unexplained symptoms (MUS) and associated syndromes (Salmon, 2007; Creed, Henningsen & Fink, 2011). MUS is a general term for syndromes without a known pathological cause. The use of the term itself is also often problematic given the negative connotations. Indeed many patients prefer the use of alternative terms including “persistent physical symptoms” (Marks and Hunter, 2015). The current review assesses the effectiveness of brief interventions for medically unexplained symptoms, illness anxiety disorder, somatic symptom disorder, health anxiety and non-cardiac chest pain. Although there may be a degree of overlap within these, it is important to outline what distinguishing features there may be.

Some of the most pronounced revisions within the latest version of the DSM-V relate to MUS (American Psychiatric Association, 2013). A new category (‘Somatic Symptom and Related Disorders’) has been created, wherein MUS fits. The category includes diagnoses of Somatic Symptom Disorder (SSD) which replaces the term MUS, and Illness Anxiety Disorder (IAD) which replaces Health Anxiety. The term hypochondriasis is no longer referred to. The key difference between MUS and SSD is that SSD accounts for cases where symptoms may have an underlying pathology, but there remains an exaggerated response. However, given that SSD also includes cases where there is an absence of pathological cause (i.e. MUS), the term has been

included in the current review in addition to a specific SSD, non-cardiac chest pain (NCCP). The terms IAD and Health Anxiety are both used to refer to the preoccupation with having a serious illness; somatic symptoms may not be present, or may present in mild form. MUS and IAD may therefore present in isolation or comorbidly; this is determined by the presence (or not) of physical symptoms without pathological cause, and the subsequent response to these.

Up to one third of individuals with physical health presentations have medically unexplained symptoms (MUS) (Kirmayer, 2004). The prevalence of MUS within the general population and more particularly within medical settings is high (Creed and Barsky, 2004; Gureje et al., 1997). MUS and Health anxiety are both associated with increased costs accrued through frequent and inappropriate use of healthcare services, absenteeism and long-term unemployment (Nezu et al., 2001; Barsky, Orav & Bates, 2005). It has been estimated that annual healthcare service costs resulting from psychosomatic symptoms are approximately £3 billion in the UK (DoH, 2011).

7.1.2 The role of depression and anxiety

Pain is one of the most commonly presented MUS (DoH, 2008). Physical symptoms are highly prevalent in depression and may result in chronic pain and impede treatment effectiveness. Depression and pain are influenced by the same neurochemical processes, therefore both must be treated simultaneously in order to achieve improvements. Previous research has demonstrated that improvements in depressive symptoms was correlated with the improvement of some physical symptoms (Trivedi, 2004). The prevalence of depression and anxiety among MUS patients has been estimated at 70% (DoH, 2008). The division between services for physical health problems and mental health disorders reinforces the notion of body

and mind as entirely separate entities, consequently adding to the psychological distress associated with MUS (Mayou et al., 1997). In relation to NCCP specifically, higher levels of anxiety have been detected among individuals with NCCP compared with health individuals (Smeijers et al., 2014). Given that medically unexplained symptoms and pain have high levels of psychiatric comorbidity it has been suggested that a multidisciplinary intervention strategy may be appropriate (Von Korff et al., 2005).

7.1.3 Psychological Interventions.

1) MUS/SSD

Qualitative research has reported that individuals with MUS have a tendency to reject psychological constructs of their problems (Chew-Graham, Brooks & Wearden, Dowrick & Peters, 2011), resulting in an unwillingness to engage in psychological treatments (Shaw and Creed, 1991; Nezu, Nezu & Lombardo, 2001). However other studies have suggested that a significant percentage of these patients would consent to undergo psychological or psychiatric interventions (Speckens, Van Hemert, Spinhoven, Hawton, Bolk, & Rooijmans, (1995). Evidence suggests that CBT is beneficial in the treatment of MUS (Malouff, Thornsteinsson, Rooke, Bhullar, & Schutte, 2008; Moss-Morris, McAlpine, Didsbury & Spence, 2010). Van Dessel et al., (2014) carried out a systematic review and meta-analysis of non-pharmacological interventions for somatoform disorders and MUPS in adults. Psychological therapies irrespective of modality were more beneficial overall than standard care or waiting lists in relation to reducing symptoms severity. Fourteen from twenty one studies included in the review and subsequent analysis focused on CBT based interventions. CBT was determined to be more effective in reducing the severity of MUPS, but there was insufficient evidence to support the efficacy of

other modalities. Furthermore, although there is a robust evidence base demonstrating the effectiveness of high intensity cognitive behavioural therapy for somatoform related disorders, there are limited reviews investigating the effectiveness of low intensity or brief psychological interventions.

Kroenke and Swindle (2000) carried out a critical review of 31 controlled clinical trials including 1600 patients where CBT was employed as an intervention for somatization and symptoms syndromes. CBT contributed to the improvement of physical symptoms in 71% of studies, functional status in 47% and psychological distress in 38%. Furthermore, group therapy and brief treatments of 5 sessions were also found to be effective, with benefits maintained for up to one year. The review concluded that CBT is an effective intervention for this patient population, and that benefits were achievable even if psychological distress was not entirely alleviated.

Similarly, although the focus was not on brief or low intensity treatments, Chavooshi, Saberi, Tavallaie & Sahraei (2017) carried out a randomised clinical trial comparing an intensive psychodynamic therapy and CBT for patients with medically unexplained pain. Findings indicated that both groups achieved reductions in psychological distress, catastrophic thinking and depression, and interventions were deemed to be equally effective at a three month follow up. The CBT group however, demonstrated an improvement in self-efficacy that was not observed in the other group.

In relation to low intensity (brief) interventions, patients attending an IAPT pilot site specifically tailored for long term conditions (LTC)/MUS referrals were offered either a low intensity CBT (guided self-help delivered by a Psychological Wellbeing Practitioner) based intervention, or a mindfulness-based stress reduction treatment (brief, low intensity interventions). Subsequent thematic analysis of qualitative

interviews indicated that patients typically reported a positive treatment experience, and felt better able to manage symptoms, even if this was not necessarily reflected by psychometric scores on the PHQ-9, GAD-7 and the WSAS. Although these interventions have been determined as appropriate for these patient groups, it has been suggested in terms of evaluation, that routine outcome measures may not entirely capture the true benefits of interventions (Gerskowitch, Norman & Rimes, 2015). It is also important to consider the clinical implications of these initial findings, namely that there were a higher number of LTC referrals compared with MUS. This may be partly explained by previous reports that GPs feel inadequate and discouraged when dealing with MUS cases (Wileman, May & Chew-Graham, 2002). Furthermore, as previously highlighted, research has indicated that MUS patients believe there is disparity between their physical symptoms and a psychological intervention (Unigwe, Rowett & Udo, 2014). The difference in referral rates between LTC and MUS patients suggest a need for separate dedicated services for each of these patient groups (Kellett et al., 2016).

2) *NCCP*

Current reviews of clinical care have highlighted a failure to appropriately manage NCCP despite the substantial prevalence rates (Chambers et al., 2015). Studies to date have pointed to the efficacy of cognitive behavioural therapy (Spinhoven, Vender Does, Van Dijk & Van Rood, 2010; Marchand et al., 2012). The efficacy of cognitive behavioural therapy as an intervention for NCCP has been evaluated in a number of randomised controlled trials (George, Abdallah, Maradey-Romero, Gerson & Fass, 2016). Mayou et al. (1997) compared CBT and standard clinical advice among NCCP patients and found major reductions in both the frequency and

severity of symptoms in the CBT group, and only modest improvements within the control group.

Similarly Spinhoven et al. (2010) conducted an RCT with UCP patients and found that those who had completed a course of CBT had a significantly higher treatment response when compared with placebo and medication groups. Keefe et al. (2011) found that a low intensity CBT intervention, more specifically “coping skills” resulted in significant improvement relating to the catastrophizing of pain symptoms and anxiety when compared to a placebo group.

Recent research has also emphasised the success of brief cognitive behavioural therapy; Jonsubu, Martinsen, Morken, Moum, and Dammen, (2013) found a three session CBT intervention to be effective for UCP patients in terms of illness perception. Beek et al. (2013) concluded that a brief cognitive behavioural intervention significantly reduced levels of anxiety and depression in patients with NCCP, with a diagnosis of panic and/or a depressive disorder based on HADS (Hospital anxiety and depression scale) scores. Based on these findings, Beek et al. (2013) recommended that individuals presenting with NCCP should be assessed for psychopathology, and a cognitive behavioural intervention offered in cases where psychological difficulties are detected. Lessard et al. (2012) found that cognitive behavioural interventions as brief as even a single session initiated within two weeks of an emergency attendance for the primary complaint of chest pain, seem to be effective for panic disorder. Furthermore, they have recommended that increased efforts should be employed to implement these interventions in the emergency department/primary care setting, considering the high prevalence of panic disorder there.

3) HA/IAD

Cooper, Gregory, Walker & Lambe (2017) carried out a recent systemic review and meta-analysis evaluating CBT for health anxiety and found a large effect size for CBT compared with several control conditions including standard care, waiting lists, medications and other psychological therapies. Van Gils et al., (2016) conducted a systematic review and met-analysis from which findings suggested self-help was associated with significant reduction in symptom severity and improvement in quality of life measures among individuals with medically unexplained symptoms. Low intensity interventions which are brief and facilitate flexible delivery have been determined as effective for identified health anxiety within medical settings (Tyrer, Cooper, Salkovskis & Crawford, 2014).

7.1.4 Aims

A recent Northern Ireland based study determined that 58,7% of all chest pain presentations to an ED in Northern Ireland across a three year period resulted in a diagnosis of NCCP (McDevitt-Petrovic, Kirby & Shevlin, 2017). However, care pathways and guidance on the most appropriate interventions for this patient population are very unclear. To date a consolidated and systematic review has not been carried out. In light of these findings, and given the lack of reviews focused on *brief or low intensity* treatments, the purpose of the current review was to assess the effectiveness of brief interventions which may be suitable for this particular, and similar patient populations. Given that there is a high prevalence of MUS within primary care with possible associated anxiety, this review sought to examine evidence for brief interventions which may in principle, improve ease of access to appropriate treatment within a stepped care approach, and be implemented at a

reduced cost compared with higher intensity or longer term treatments in secondary care. To ensure a more robust assessment, conditions which may exist comorbidly with NCCP were included. Therefore the current review specifically aimed to assess the effectiveness of brief interventions for medically unexplained symptoms, illness anxiety disorder, somatic symptom disorder, health anxiety and non-cardiac chest pain, accounting also for the recent changes in terminologies and diagnostic criteria within the DSM-V.

7.2. Method

7.2.1 Eligibility criteria

Studies were assessed for eligibility for inclusion as per the following criteria: (1) written in the English language; (2) published in a journal; (3) included a quantitative evaluation of a brief intervention, with brief defined as ten or fewer individual of group based treatment sessions; (4) interventions were aimed at reducing the frequency and/or impact of medically unexplained symptoms, health anxiety, somatic symptoms disorder, illness anxiety disorder, or non-cardiac chest pain; (5) participants were over 18 years of age; (6) outcome measures indicated the degree of medically unexplained symptoms, and/or psychological wellbeing pre and post intervention. (6) randomised controlled trial, with control group(s) Studies were assessed by author (OMDP) and those which were inconclusive were referred to a supervisor (KK) for assessment.

7.2.2 Search strategy

Three databases, specifically Google Scholar, PubMed, and Web of Science were searched in September 2017 for full-text articles which were published in peer reviewed journals. Combinations of the following keywords were used: brief* and

intervention*, treatment*, therapy*. The key search terms were (1) medically unexplained symptoms (2) health anxiety, (3) somatic symptom disorder, (4) illness anxiety disorder and (5) non-cardiac chest pain. Table 1 indicates the complete search strategy employed in Google Scholar advanced searches, which was subsequently modified for the remaining searches. The reference lists of the articles selected from database searches were also examined.

Table 7.1: Search strategy used in Google Scholar

Searches
a) brief intervention*
b) brief treatment*
c) or brief therapy*
d) and exact phrase medically unexplained symptoms
e) or somatic symptom disorder (exact)
f) or illness anxiety disorder (exact)
g) or health anxiety (exact)
h) or non-cardiac chest pain (exact)

7.2.3 Study selection

Studies were selected by (1) screening the titles; (2) screening the abstracts and methodologies; (3) reviewing the complete paper if the title, abstract and methodologies did not present conclusive evidence that the inclusion criteria were achieved. Studies which did not meet inclusion criteria were subsequently disregarded.

7.2.4 Data extraction

Data were extracted according to PRISMA guidelines, onto an Excel workbook which was used throughout the searches and the review. This was used specifically to record information about study and participant characteristics, details of interventions, outcome measures and analyses.

7.2.5 Risk of Bias

The Cochrane Collaboration Risk of Bias Tool was used in order to assess the risk of bias in the studies selected for the review. This involved screening for bias risk in relation to sequence generation, allocation concealment, blinding of participants and assessors, incomplete data, selective reporting and any other relevant bias. OMDP and a supervisor (KK) independently reviewed the selected studies and subsequently agreed on the level of risk of bias as either low, unclear or high.

7.2.6 Protocol and registration

The study will be registered with PROSPERO, an international database of prospectively registered systematic reviews.

7.3. Results

7.3.1 Study selection

The literature search and search of additional resources (reference lists of full texts articles selected for screening), yielded a total of 1674 studies. After removal of duplicates the total was 885. Studies were initially excluded based on title only, and subsequently based on title abstract and methods. A final decision to exclude was taken after full text screening indicated a study did not meet inclusion criteria. 100

full text articles were screened for eligibility after which 23 studies were selected (see Figure 7.1). All studies included controlled trials.

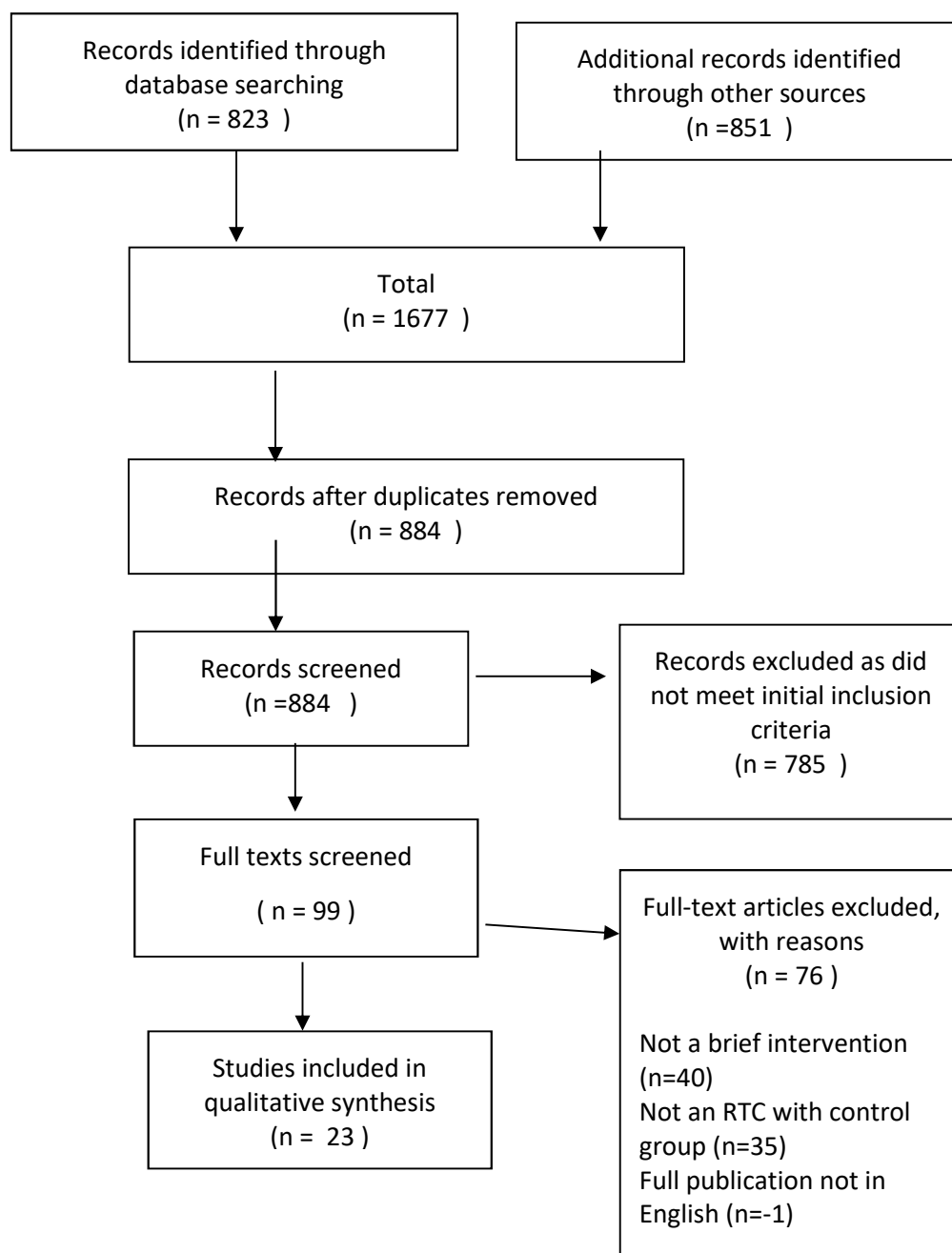


Figure 7.1. Prisma flow diagram of search results and selected studies

Table 7.2: Characteristics of Selected Studies

Studies	Participants			Brief Interventions			Outcome measures	
	N	Location	Age (Yrs)	Gender	Type of intervention	Duration of treatment session	Duration of treatment course	Primary and secondary measures used to assess physical symptoms, somatisation ,mental health and functioning
Escobar et al., (2007)	172	USA	18-75	m f	time limited CBT-type	45-60 minutes	maximum of 10 sessions	CGI –S, CGI-I, VAS,MOS-10, HAM-D, HAM-A
Aiarzaguena et al., (2007)	156	Spain	18-65	m f	Psychosocial and communication intervention	30 minutes	maximum of six sessions	MOS, SF-36,CIDI, PRIME-MD,SLE, NAS
Martin et al., (2007)	140	Germany	full range unspecified	m f	Single session CBT	3-4 hours	One session	BSI-SOM,SOMS-7 BSI-GSI, WI, BDI,KKG-I
Arnold et al., (2009)	65	Netherlands	42-52	m f	Time limited CBT	45 minutes	maximum of 5 sessions	PSC-51, HADS, MOS SF-36

Katsamanis et al., (2011)	48	USA	full range unspecified	m f	Time limited psychophysiological intervention	not specified	maximum of 10 sessions	CGI-S, HAM-A, HAM-D
Wortman et al., (2016)	42	Netherlands	full range unspecified	m f	Brief multimodal psychodynamic therapy	45 minutes	maximum of 9 sessions	VAS, NHL, 4DSQ, SF-36 MAF
McManus et al., (2012)	74	UK	18-65	m f	Time-limited mindfulness cognitive therapy	2 hours	maximum of 8 sessions	DSM-IV (structured clinical interview), SHAI, WI,BAI BDI
Tyrer et al., (2014)	444	UK	16-75	m f	Time limited CBT	not specified	5-10 sessions	HADS, SFQ-36, EQ-5D
Sanders et al., (1997)	57	UK	full range unspecified	m f	Brief psychoeducation based on CBT	1 hour	1 face to face session and 2 brief follow-up phonecalls.	BDI, STAI, SF-36, WI, SCL-90
Jonsbu et al., (2011)	41	Norway	18-65	m f	Short-term CBT	60-90 minutes	maximum of 3 sessions	BSQ, SF-36, BDI, HRQOL
Bahreman et al., (2015)	41	Iran	35-75	m f	Relaxation training or metaphor therapy	2 hours	maximum of 4 sessions	BPI, JIBT

Mourad et al., (2016)	15	Sweden	22-76	m f	Guided internet therapy (CBT based)	Not specified	maximum of 4 sessions	CAQ, BSQ, PHQ-9
van Beek et al., (2013)	113	Netherlands	Over 18	m f	Brief CBT	45 minutes	maximum of 6 sessions	CGI, HADS, MINI, STAI, FQ
Esler et al., (2003)	59	USA	19-70	m f	Brief	1 hour	1 session	CHEST PAIN INTERVIEW, ASI, CAQ, SF-36, BSI
Barsky et al., (2004)	187	USA	Over 18	m f	Time limited CBT	90 minutes	maximum of 6 sessions	WI, HAI, HCQ, SSI, FSQ, SCL-90, SIS
Bahreman et al., (2016)	28	Iran	37-56	m f	Metaphor therapy	2 hours	maximum of 4 sessions	PDS, DASS,
Pelland et al., (2011)	47	Canada	18-80	m f	Brief CBT or pharmacological treatment	1 hour	maximum of 7 sessions	ADIS-IV, ACQ, ASI, PAS, BDI, CAQ
Allen et al., (2006)	84	USA	range not specified	m f	Time limited CBT	not specified	maximum of 10 sessions	CGI-SD, SF-36, SSS
Larisch et al., (2004)	127	Germany	range not specified	m f	Brief Psychosocial	20 minutes	maximum of 6 sessions	HADS, SF-36, GHQ,-12, SOMS

Lessard et al., (2012)	58	Canada	21-81	m f	Brief panic management (PM) or brief CBT	2 hours (PM) 1 hour (CBT)	1 session (PM) 7 sessions (CBT)	ADIS-IV, BSQ, PAS, ASI, CAQ, ACQ
Kashner et al., (1995)	70	USA	range not specified	m f	Short-term group therapy	2 hours	8 sessions	SF-36
Avia et al., (1996)	14	Spain	18-38	m f	Short-term group based educational CBT	90 minutes	6 sessions	IAS, SDIH, BDI, FSS, DAS, QOL, DHBQ, NEO-PI
Potts et al. (1999)	60	UK	range not specified	m f	Short-term group psychological (CBT based) treatment	2 hours	6 sessions	HADS, NHL, SIP, NHP

SOMATOFORM SYMPTOMS SCALE; **BSI-GSI** : GLOBAL SEVERITY INDEX; **BDI** : BECK DEPRESSION INVENTORY; **KKG-I**: 'INTERNAL CONTROL' MULTIDIMENSIONAL SELF-REPORT QUESTIONNAIRE; **WI**: WHITELY INDEX; **PSC-51** : PHYSICAL SYMPTOMS CHECKLIST; **HADS** : HOSPITAL ANXIETY AND DEPRESSION SCALE; **NHL** : NIJMEGEN HYPERVENTILATION LIST; **4DSQ** : FOUR-DIMENSIONAL SYMPTOM QUESTIONNAIRE (DISTRESS, ANXIETY, DEPRESSION, SOMATIZATION); **MAF** : MEASURE OF GENERAL FUNCTIONING; **EQ-5D** : HEALTH RELATED QUALITY OF LIFE; **STAI** : STATE TRAIT ANXIETY INVENTROY; **SCL-90**: SYMPTOM CHECKLIST; **BSQ** : BODILY SENSATIONS QUESTIONNAIRE; **HRQOL** : HEALTH RELATED QUALITY OF LIFE; **BPI** : BRIEF PAIN INVENTORY; **JIBT** : JONES IRRATIONAL BELIEF TEST; **PHQ-9** : PATIENT HEALTH QUESTIONNAIRE (DEPRESSION); **CAQ** : CARDIAC ANXIETY QUESTIONNAIRE; **FQ** : FEAR QUESTIONNAIRE; **MINI** : MINI INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW; **ASI** : ANXIETY SENSITIVITY INDEX; **HCQ** : HYPOCHONDRIAL COGNITIONS QUESTIONNAIRE; **SSI** : SOMATIC SYMTOMS INVENTORY; **FSQ** : FUNCTIONAL STATUS QUESTIONNAIRE; **SIS** :SEVERITY OF ILLNESS SCALE;**PDS** :PAIN DISCOMFORT SCALE; **DASS** : DEPRESSION, ANXIETY, STRESS SCALE; **PAS**: PANIC, AGORAPHOBIA SCALE; **ADIS-IV** : ANXIETY DISORDER INTERVIEW SCHEDULE; **SSS** : SEVERITY OF SOMATIC SYMPTOM SCALE; **GHQ** : GENERAL HEALTH QUESTIONNAIRE; **SUI** : SUMMARY UTILITY INDEX; **ACQ** : AGORAPHOBIC COGNITIONS QUESTIONNAIRE; **IAS** : ILLNESS ATTITUDE SCALE; **SDIH** : STRUCTURED DIAGNOSITC INERVEIEW, HYPOCHONDRIASIS; **FSS** : FEAR SURVEY SCHEDULE; **DAS** : DYSFUNCTIONAL ATTITUDE SCALE; **QOL** : QUALITY OF LIFE QUESTIONNAIRE; **DHBQ** : DYSFUNCTIONAL HEALTH BELIEFS QUESTIONNAIRE; **NEO-PI** : PERSONALITY INVENTORY; **SIP** : SICKNESS IMPACT PROFILE; **NHP** : NOTTINGHAM HEALTH PROFILE

Table 7.3: Risk of bias in selected studies

Authors and year	Adequate sequence generation	Allocation concealment	Blinding of participants and personnel	Blinding of outcome assessors	Incomplete outcome data addressed	Free of selective reporting	Free of other bias
Escobar et al., (2007)	Low	Low	Low	Low	Unclear	Low	Low
Aiarzaguena et al., (2007)	Low	Low	Low	Unclear	Unclear	Low	Low
Martin et al., (2007)	Low	Low	Low	High	Unclear	Low	Low
Arnold et al., (2009)	Unclear	Low	Low	Low	Unclear	Low	Unclear
Katsamanis et al., (2011)	Low	Low	Low	Unclear	Unclear	Low	Unclear
Wortman et al., (2016)	Low	Low	Low	Low	Unclear	Low	Unclear
McManus et al., (2012)	Low	Low	Low	Low	Unclear	Low	Unclear
Tyrer et al., (2014)	Low	Low	Low	Low	Unclear	Low	Unclear
Sanders et al., (1997)	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear
Jonsbu et al., (2011)	Unclear	Unclear	High	Unclear	Unclear	High	Unclear
Bahremand et al., (2015)	Low	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear
Mourad et al., (2016)	Low	Low	Low	Low	Low	Low	Unclear

[illegible]

7.3.2 Study Characteristics

1) Location

A summary of the selected studies is presented in Table 2. Studies originated in the USA ($n = 6$), Spain ($n = 2$), Germany ($n = 2$), Netherlands ($n = 3$), UK ($n = 4$), Iran ($n = 2$), Norway ($n = 1$), Sweden ($n = 1$) and Canada ($n = 2$). In seven of the studies, the purpose was to evaluate the effect of interventions on medically unexplained symptoms. The remaining studies investigated intervention effects on somatisation ($n = 3$), health anxiety ($n = 2$), hypochondriasis ($n = 2$) and non-cardiac chest pain (10). All studies considered effectiveness in terms of physical symptoms and psychological wellbeing.

2) Participants

All of the included studies involved both male and female participants, and ages ranged from 16 to 81. The total number of participants varied in each of the studies. Eleven of the studies included less than 60 participants , 4 studies included between 61 and 100 participants, 3 studies included between 101 and 150 participants, 4 studies included between 151 and 200 participants and one study involved 444 participants (see Table 7.2).

3) Sample Size

All studies employed selective sampling methods (purposive), whereby potential participants were initially identified by health professionals prior to subsequent additional eligibility screening using diagnostic interview and psychometric questionnaires. Five studies concurrently used opportunistic sampling methods (through public advertising) prior to the additional screening. Six studies provided

some details of power calculations made in order to determine optimum sample sizes. The remaining studies did not describe how sample size was calculated.

4)Unit of Allocation and Risk of Bias

All of the included studies used random allocation to intervention or control groups. However, one of these studies (Jonsbu et al., 2011) did not allocate participants in a conventional way, given that they were not actually randomly assigned to conditions, but rather the decision was taken by the authors (for ethical reasons) that the order of the three condition cohorts should be randomly predetermined. The judgements for risk of bias are presented for each of the included studies in table 7.3.

5) Theoretical basis of the interventions

All of the interventions had a psychological basis. Cognitive behavioural therapy formed the theoretical basis of the interventions in 17 of the studies. Two studies described the intervention as psychosocial and communicative. One study described the intervention as psychophysiological , and one study used a brief psychosomatic intervention . Two studies used relaxation and metaphor therapies. Interventions were delivered as individual sessions in the majority of studies (n =20), and interventions were delivered in a group basis in the remaining studies (see table 7.2)

6) Duration

The studies selected for the current review varied in their duration from six months to four years.

7) Control Conditions

The vast majority of the selected studies ($n = 21$), employed a ‘treatment as usual’ control condition. The remaining 2 studies, specifically Avia et al. (1996), and Potts et al. (1999) employed ‘waiting list’ control conditions.

7.3.3 Interventions: description and impact

1) MUS/SSD

Brief CBT

The cognitive behavioural model (Beck, 1976) considers predisposing, precipitating and perpetuating factors. Psychological distress may be triggered and maintained in individuals with physical health symptoms via a cycle of inaccurate perceptions, avoidance behaviours and subsequent intensification of symptoms. Four of the selected studies included brief CBT based interventions targeting MUS/SSD.

Escobar et al. (2007) assessed the effectiveness of a 10 session treatment (averaging 50 minutes duration), which had been modified to target somatization problems.

More specifically it applied relaxation training, emotional awareness, cognitive restructuring (CR) and communication. Another study (Martin et al., 2007)

facilitated a single session (3-4 hours) which focused primarily on developing psychophysiological explanations of symptoms, relaxation, cognitions and

healthcare use. Arnold et al. (2009) based their brief CBT intervention on the Consequences model (Speckens et al., 1995) within which the focus is on the

consequences as opposed to the causes of physical symptoms; applied techniques aim to alter the consequences of symptoms. Participants were offered a maximum of 5, 45 minute sessions. The final study assessing brief CBT for MUS (Allen et al.,

2006), offered a 10 session manualized intervention adapted for somatization disorder aimed at coping with stress and physical discomfort.

Of the five studies which implemented brief CBT interventions targeting MUS/SSD, significant effects were observed in three whereby the intervention was deemed to be effective relative to control groups. No significant effects were observed in one study. Escobar et al., (2007) reported medium effect sizes, and found that the intervention group had a higher percentage of patients with 'very much' or 'much' improved physical symptoms as reported by blinded evaluators (60% vs 25.8% odds ratio = 4.1; 95% CI, 1.9-8.8; $p < .001$). There was a significant improvement in the intervention vs the control group ($p < 0.5$) for depressive symptoms. Effects however were no longer noticeable at six month follow-up. Small to medium effect sizes were observed by Martin et al., (2007), and a stronger effect size was detected for the intervention group in relation to reduction of doctors' visits ($\eta^2 = 0.031$), and the reduction of somatization severity ($\eta^2 = 0.048$). Although significant improvements in all other measures were observed for both groups, all participants were still highly impaired with the degree of somatization, health anxiety and depression all above clinical thresholds at a six month follow-up. Allen et al., (2006) observed large effect sizes and found that somatization symptoms were significantly improved in the intervention group relative to the control group ($p < 0.01$), with the intervention also associated with improved self-reported functioning. Arnold et al. (2007) determined that the intervention was not more effective than care as usual, although approximately 30% of participants in both groups demonstrated improvements on the clinically relevant outcomes.

Brief psychosocial interventions

Two of the included studies used psychosocial and communication interventions targeting MUS/SSD. One study (Aiarzaguena et al., 2007), trained GPs to explain symptoms in a physical tangible way as result of hormone imbalance, to subsequently attribute this imbalance to irrational thinking, and to explore psychosocial issues indirectly. Participants were offered six sessions of 30 minutes.

Similarly, Larisch et al. (2004), trained GPs to gather a thorough psychosocial history, evaluate subjective understanding, demonstrate empathy, explain the relationship between symptoms and emotional distress, use symptom diaries, identify stressors and develop new behaviours; six 20 minute sessions were offered.

Two studies evaluated a psychosocial intervention for MUS/SSD delivered by GPs. Aiarzaguena et al. (2007) observed small to medium effect sizes and large effects sizes for bodily pain, social and emotional functioning, and mental health. More specifically, quality of life dimensions in the intervention group were significantly improved relative to the control group in relation to several SF-36 subscales, namely bodily pain ($p < 0.03$), mental health ($p < 0.063$), physical functioning ($p < 0.01$), vitality ($p < 0.039$), social functioning ($p < 0.033$), and utility index ($p < 0.039$).

Larisch et al., (2007) found significant improvements were observed for the intervention group relative to the control group in relation to a reduction of physical symptoms ($p = 0.07$), reduction of depression ($p = 0.211$) and reduction of anxiety ($p = 0.388$). Effect sizes however were modest and were not maintained at six month follow up.

Brief Psychophysiological Interventions

One of the selected studies (Katsamanis et al., 2011), used a brief psychophysiological intervention targeting MUS/SSD. This was a ten session

manualized treatment designed specifically for MUS; it was described as a treatment to assist with stress and physical discomfort, and specific components were emphasized depending on individual symptoms profiles.

Brief Multimodal Psychosomatic Therapy

One study (Wortman et al., 2016), used a brief multimodal psychosomatic therapy targeting MUS. The treatment is based on the biopsychosocial model and involved relaxation, mindfulness, CBT techniques and activation therapy; up to 9 session of 45 minutes duration were offered.

At 12 months post intervention, Wortman et al. (2016) observed improvement in perceived symptom severity [adjusted mean difference -2.0 , 95% confidence interval (CI) -3.6 to -0.3], in somatization (adjusted mean difference -4.4 , 95% CI -7.5 to -1.4) and in symptoms of hyperventilation (adjusted mean difference -5.7 , 95% CI -10.5 to -0.8). Although the small sample size was deemed to be efficient, the authors concluded that a larger trial would be helpful and feasible. This pilot trail was not powered to indicate treatment effect size.

Brief Group Therapy

One study (Kashner et al., 1995), implemented a short-term group therapy for MUS/SSD (8 session of 2 hour durations), within which the aims were to develop peer support, share coping strategies and improve perceptions and expressions of emotions.

In relation to a brief group therapy, the intervention group demonstrated significant improvements compared with the control group on both physical health ($p < 0.05$), and mental health ($p < 0.01$) at post-treatment and at 12 month follow-up.(Kashner et al., 1995). Treatment effect sizes were not indicated

2) HA/IAD

Brief CBT

Four of the included studies implemented brief CBT interventions targeting HA/IAD. Tyrer et al. (2014), offered 5-10 sessions of brief CBT which had been adapted for HA. Similarly, Barsky et al. (2004) employed a 6 session individualized intervention which was designed specifically to target and restructure hypochondrial thoughts. One study (McManus et al., 2012) implemented a time-limited group mindfulness-based CBT intervention (Segal, Williams & Teasdale, 2002), which was described a skills training programme adapted for HA (McManus, Muse & Saraway, 2011). A group based intervention was also employed by Avia et al. (1996). This took the form of an educational course aimed at improving coping skills for HA, focused specifically on selective attention, muscle tension, breathing, environmental factors, stress, mood and explaining somatic symptoms.

Four of the included studies implemented brief BCT interventions targeting HA/IAD and all reported significant effects for intervention groups relative to control groups. More specifically, Tyrer et al. (2014), determined small effect sizes, and found that at 12 month follow-up point, the intervention group demonstrated an improvement in health anxiety symptoms which was 2.98 points greater than the control group and these symptomatic improvements were maintained at 2 years follow up. However, there were no significant differences between groups in relation to social functioning or health related quality of life. At a 12-month follow-up, Barsky and Ahern, (2004) found significantly lower levels of hypochondriacal symptoms, beliefs, and attitudes ($P < .001$) and health-related anxiety ($P = .009$). in the intervention group. Furthermore significantly less impairment of social role functioning ($P = .05$) and

intermediate activities of daily living ($P < .001$) were also observed. Effect sizes were reported as small to medium and hypochondriacal somatic symptoms were not improved significantly by treatment. McManus et al., 2012 determined medium effect sizes; their intervention group demonstrated significantly lower health anxiety than the control group both immediately following treatment ($d = 0.48$), and at a 12 month follow-up ($d = 0.48$). Avia et al. (1996) observed significant improvement in the intervention group relative to the control group on all measures including physical symptoms ($p = 0.03$), dysfunctional health beliefs ($p = 0.02$), vulnerability ($p = 0.03$) and lack of control ($p = 0.06$); effect sizes were not reported.

3) NCCP

Brief CBT

Seven of the selected studies involved brief CBT based interventions targeting NCCP. Pelland et al. (2011) implemented a 7 session treatment which incorporated psychoeducation on chest pain, panic disorder (PD), exposure and CR. Two interventions were evaluated in another study (Lessard et al., 2012), namely a single session panic management intervention and a 7 session CBT treatment for NCCP and PD. Sanders et al., (1997), also trialled a single individualized information session with psychoeducational materials. Esler et al. (2003), also used a single session of brief CBT (60 minute duration) which included psychoeducation, breathing exercises and CR. Psychoeducation was again a component of the intervention offered in a study by van Beek et al. (2013), which also included CR, and strategies to influence avoidance behaviours over 6 sessions of 45 minutes. One study (Jonsbu et al., 2011), offered a 3 session programme (60-90 minutes) which focuses on the CBT model of panic and exposure therapy. Guided brief CBT was

delivered online in one study (Mourad et al., 2016), and involved 4 sessions of psychoeducation, physical activity advice and relaxation.

Of the seven selected studies which implemented brief CBT based interventions targeting NCCP, five reported significant effects for interventions relative to control groups and two observed no significance. Pelland et al. (2011) observed large treatment effect sizes. Both intervention groups demonstrated significant improvements relative to the control group in relation to the severity of panic disorder ($p = 0.12$), frequency of panic ($p = 0.48$), and depressive symptoms ($p = 0.27$). Lessard et al. 2012 evaluated 2 brief interventions and observed large effect sizes. Both interventions also achieved significant reductions in the severity of panic disorder relative to the control group ($\eta^2 = 0.07$), although no superiority was demonstrated by one intervention as compared with the other. Esler et al. (2003) found medium effect sizes with significant improvements for the intervention versus control in relation to frequency and fear of chest pain, and anxiety sensitivity, but not in relation to severity of chest pain, quality of life and psychological distress. In another study, significant improvements were observed for intervention versus control group in relation to reduction of disease severity, anxiety and depression symptoms (van Beek et al., 2013) but effect sizes were not determined. Jonsbu et al., 2011 found their brief CBT intervention was effective compared to care as usual and reported medium to large effect sizes. Significant differences were observed for fear of bodily sensations, avoidance of physical activities and depression. However the sample size was small and no power analysis was carried out. Mourad et al. (2016) found that although improvements were demonstrated by both intervention and control groups in relation to cardiac anxiety, fear of bodily sensations and depression, no significant differences were observed between the groups. Similarly,

Sanders et al., (1997) found that although both groups achieved slight improvements on the main outcomes, specifically chest pain, mood and limitation of activities, no significant effects were observed.

Relaxation and metaphor therapy

Two studies (Bahreman et al., 2015; Bahreman et al., 2016), evaluated relaxation and metaphor therapies targeting NCCP. Both treatments consisted of 4 2 hour sessions. The relaxation therapy was group based involving learning and practising relaxation and breathing techniques. Metaphor therapy involved challenging and connecting metaphoric stories of hopelessness, with the ultimate goal of challenging unhelpful beliefs.

Two studies evaluated relaxation and metaphor therapies targeting NCCP. The first of these reported small to medium effect sizes, and determined significant differences between the relaxation group and both control groups for hopelessness ($DM=9.79$, $p < 0.05$), pain severity ($DM=1.96$, $p < 0.05$), and emotional irresponsibility ($DM= 4.80$, $p < 0.05$). No significant effects were observed in relation to the metaphor therapy intervention group (Bahreman et al., 2015). In their subsequent study, Bahreman et al. (2016) assessed the effectiveness of metaphor therapy only, and again determined no significant treatment effects relative to the control group.

Short-term group therapy

One study (Potts et al., 1999) implemented a short-term (8 session of 2 hours) group therapy for NCCP within which the focus was on sharing experiences and coping strategies, education on chest pain, relaxation and breathing exercise, physical exercise , CR and graded exposure. Significant improvements were observed in the

intervention group relative to the control group in relation to chest pain episodes ($p < 0.01$) and anxiety and depression ($p < 0.05$), with benefits maintained at a six month follow-up. Treatment effect sizes were not indicated.

7.3.4 Delivery of the intervention

Therapists trained specifically in the relevant interventions were used in eleven of the studies. Primary care physicians (GPSs) delivered interventions in four of the studies, and four of the studies used clinical psychologists to deliver treatments. Cardiac nurses delivered interventions in two studies (see table 7.4).

7.3.5 Outcome measures

Several combinations of primary and secondary outcome measures including questionnaires and diagnostic interviews were used in the selected studies at pre, post and follow-up points. The measures assessed medically unexplained symptoms, mental health, health related quality life and general functioning. The most frequently used outcome measure was the MOS SF-36 (medical outcomes study 36 item short-form health survey), which was used in ten of the selected studies. A full list of the outcome measures used in each of the included studies is presented in table 7.2. Intervention effects are presented in Table 7.4.

7.3.6 Pre, Post and Follow-up data

The majority of the studies ($n = 17$) included in the review adapted longitudinal designs and evaluated outcomes at pre and post intervention points and at one or more follow-up points. Six of the included studies evaluated outcomes at pre and post intervention points only, and did not use a longitudinal design.

7.3.7 Use of incentives

The majority of studies included in the review either did not use or did not make reference to the use of incentives to reward participants or those delivering interventions. However in one study (Martin et al., 2007), physicians who initially identified patients who subsequently participated in the trial, were given a financial award of €20 per subject, and a second study (Arnold et al., 2009), provided an financial compensation (amount not disclosed) to GPs who delivered interventions. Regarding financial compensation for participants, this was provided (\$10) in one study (Esler et al., 2003), and lotto tickets worth \$10 were given to participants for returning completed questionnaires in another study (Jonsbu et al., 2013).

Table 7.4 Summary of results for included studies

Authors & Year	Nature of intervention	Result summary/conclusion
Escobar et al. (2007)	Time limited CBT type therapy delivered in primary care for patients with medically unexplained physical symptoms	The intervention group had a higher percentage of patients with ‘very much’ or ‘much’ improved physical symptoms as reported by blinded evaluators (60% vs 25.8% odds ratio = 4.1; 95% CI, 1.9-8.8; $p < .001$). There was a significant improvement in the intervention vs the control group ($p < 0.5$) for depressive symptoms. Effects were no longer noticeable at six month follow-up. Effect sizes medium.
Aiarzaguena et al. (2007)	A psychosocial and communication intervention delivered by GPs for patients with medically unexplained symptoms.	Improvements in all dimensions of the SF-36 were demonstrated by patients in both groups. The intervention group demonstrated significantly more improvement in bodily pain, mental health, physical functioning, social functioning and vitality ($p < 0.039$). Effect sizes small to medium (large effects sizes for bodily pain, social and emotional functioning and mental health).

Martin et al. (2007)	A one session CBT intervention for medically unexplained symptoms delivered by clinical psychologist	There was a stronger effect size in the intervention group in relation to reduction of doctors visits ($\eta^2 = 0.031$), and the reduction of somatization severity ($\eta^2 = 0.048$). Although significant improvements in all other measures were observed for both groups, all participants were still highly impaired with the degree of somatization, health anxiety and depression all above clinical thresholds at a six month follow-up. Effect sizes : small to medium
Arnold et al. (2007)	Cognitive behavioural treatment delivered by family physician for medically unexplained symptoms	The intervention was not more effective than care as usual; approximately 30% of participants in both groups demonstrated improvements on the clinically relevant outcomes. No Significance observed: Intervention not effective as compared with control group. Effect sizes N/A.

Katsamanis et al. (2011)	Psychophysiological treatment (described to participants as an intervention to assist in coping with physical comfort and distress) delivered by psychologists	There was a significantly greater improvement in the frequency and severity of physical symptoms in the interventions group ($p < 0.05$). Effect sizes also indicated a greater improvement in the interventions group for depression symptoms ($d = 0.81$)
Wortman et al. (2016)	Brief multimodal psychodynamic therapy for medically unexplained symptoms delivered by trained practitioners.	Significant differences between groups were observed at 12 month follow up; the intervention group demonstrated greater improvement in perceived symptom severity, somatization and hyperventilation. Effect sizes: Unknown (trial not powered to indicate treatment effect sizes)
McManus et al. (2012)	Time-limited mindfulness-based cognitive therapy for health anxiety delivered by trained practitioners and clinicians.	The intervention group demonstrated significantly lower health anxiety than the control group both immediately following treatment ($d=0.48$), and at a 12 month follow-up ($d=0.48$). Effect sizes : medium

Tyrer et al. (2014)	CBT for health anxiety delivered by trained health professionals	At a 12 month follow-up point, the intervention group demonstrated an improvement in health anxiety symptoms which was 2.98 points greater than the control group. Significance observed: Intervention effective as compared with control group. Effect sizes small
Sanders et al. (1997)	Brief psychoeducational and cognitive behavioural intervention for non-cardiac chest pain, delivered by cardiac nurses	Although both groups achieved slight improvements on the main outcomes, specifically chest pain, mood and limitation of activities, no significant effects were observed. Effect sizes : NA
Jonsbu et al. (2011)	Short-term CBT for non-cardiac chest pain delivered by trained therapists.	The intervention was effective compared to care as usual; significant differences were observed for fear of bodily sensations, avoidance of physical activities and depression. Effect sizes medium to large

Bahreman et al. (2016)	Relaxation training versus metaphor therapy for non-cardiac chest pain delivered by clinical psychologists.	There were significant differences observed between the relaxation group and both control groups for hopelessness (DM=9.79, $p < 0.05$), pain severity (DM=1.96, $p < 0.05$), and emotional irresponsibility (DM= 4.80, $p < 0.05$). Effect sizes small to medium.
Mourad et al. (2016)	Guided internet therapy (CBT based) for non-cardiac chest pain delivered by cardiac nurses	Although improvements were demonstrated by both groups in relation to cardiac anxiety, fear of bodily sensations and depression, no significant differences were observed between the groups. No Significance observed. Effect sizes : N/A
Van Beek et al. (2013)	Brief CBT for non-cardiac chest pain with associated depression and panic disorder delivered by clinical psychologists	Significant improvements were observed for intervention versus control group in relation to reduction of disease severity, anxiety and depression symptoms. Effect sizes : Unknown (trial not powered to indicate treatment effect sizes).
Esler et al. (2003)	Brief CBT for non-cardiac chest pain	

		<p>Significant improvements were observed for intervention versus control in relation to frequency and fear of chest pain, and anxiety sensitivity, but not in relation to severity of chest pain, quality of life and psychological distress.</p> <p>Effect sizes : medium</p>
Barsky et al. (2004)	CBT for hypochondriasis delivered by trained therapists	<p>Significant differences were observed for the intervention group versus control group in relation to hypochondrial symptoms, beliefs and attitudes, health anxiety, and social functioning. Effect sizes : small to medium</p>
Bahreman et al. (2016)	Metaphor therapy for non-cardiac chest pain delivered by psychologists	<p>There were no significance differences demonstrated by the intervention group compared with control group on any of the outcome variables (depression, anxiety, stress and pain discomfort). No Significance observed:</p> <p>Intervention not effective as compared with control group</p> <p>Effect sizes : NA</p>

Pelland et al. (2011)	Brief CBT or pharmacological treatment for non-cardiac chest pain with associated panic disorder delivered by psychologists.	Both intervention groups demonstrated significant improvement relative to the control group in relation to the severity of panic disorder ($p=0.12$), frequency of panic ($p=0.48$), and depressive symptoms ($p=0.27$). Effect sizes large.
Allen et al. (2006)	Time limited CBT for somatization disorder	Somatization symptoms were significantly improved in the intervention group relative to control group ($p < 0.01$). Effect sizes large.
Larisch et al. (2004)	Psychosocial intervention for somatising patients delivered by general practitioners	Significant improvements were observed for the intervention group relative to the control group in relation to a reduction of physical symptoms ($p=0.07$), reduction of depression ($p=0.211$) and reduction of anxiety ($p=0.388$). Effects were not maintained at six month follow up. Effects not maintained at 6 month follow-up. Effect sizes small.

Lessard et al. (2011)	Brief psychological interventions (panic management and CBT) for panic disorder with non-cardiac chest pain delivered by trained therapists.	Both interventions demonstrated significant reductions in the severity of panic disorder relative to the control group ($\eta^2 = 0.07$) although no superiority was demonstrated by one intervention as compared with the other. Effect sizes large (time)
Kashner et al. (1995)	Short-term group therapy for somatization disorder delivered by trained therapists	The intervention group demonstrated significant improvements relative to the control group on both physical health ($p < 0.05$), and mental health ($p < 0.01$) at post-treatment and at 12 month follow-up. Effect sizes : Unknown (trial not powered to indicate treatment effect sizes)
Aviva et al. (1995)	Short-term group therapy (CBT based) for hypochondriasis delivered by trained therapists	Significant improvements were observed in the intervention group relative to the control group on all measures including physical symptoms ($p = 0.03$), dysfunctional health beliefs ($p = 0.02$), vulnerability ($p = 0.03$) and lack of control ($p = 0.06$). Effect sizes unknown (trial not powered to indicate treatment effect sizes)

Potts et al. (1999)

Time limited group psychological treatment for non-cardiac chest pain delivered by trained therapists

Significant improvements observed in the intervention group relative to the control group in relation to chest pain episodes ($p < 0.01$) and anxiety and depression ($p < 0.05$), with benefits maintained at a six month follow-up. Effect sizes : Unknown (trial not powered to indicate treatment effect sizes).

7.4 Discussion

7.4.1 *Summary of Evidence*

This is the first systematic review which examined evidence for brief or time-limited interventions for both MUS/SSD, HA/IAD and NCCP specifically. Significant effects for the intervention groups relative to control groups were reported in 19 studies, and 4 studies did not determine any significant benefits of interventions compared with control groups. Significant effects relative to controls were determined for all of the brief interventions in at least one study (CBT, psychosocial, psychophysiological, psychosomatic, relaxation and group therapy), with the exception of metaphor therapy for which no significant effects were reported. (Bahremand et al., 2016). Of those studies reporting significance, large treatment effects were reported in 3 (Allen et al., 2006; Pelland et al., 2011; Lessard et al., 2012), medium effect sizes were reported by 3 (Escobar et al., 2007, McManus et al., 2012; Esler et al., 2003), medium to large effects were reported in 2 (Jonsbu et al., 2013; Katsamanis et al., 2011), 4 (Martin et al., 2007, Aiarzaguena et al., 2007; Barsky & Aher, 2004; Bahremand et al., 2015) observed small to medium effect sizes, and small effect sizes were determined in 2 (Larisch et al., 2004 & Tyrer et al., 2014). 5 studies did not indicate effect sizes (see table 7.4). All of the studies within which the largest effect sizes were reported, involved brief CBT for either MUS (Allen et al., 2007), and brief CBT for NCCP (Pelland et al., 2011; Lessard et al., 2012).

There are several possible explanations for the lack of effect on medically unexplained symptoms and psychological wellbeing in the trials within which no significance was observed. The findings of Arnold et al. (2009), specifically that

time limited CBT delivered by GPs for MUS did not result in significantly better outcomes than care as usual, are consistent with other research which has outlined the limited feasibility and effectiveness of CBT for MUS delivered by primary care doctors (Arnold et al., 2004; Huibers et al., 2003).

Although Mourad et al. (2016) found that brief online CBT guided by cardiac nurses was feasible for NCCP given that it decreased cardiac anxiety, frequency of chest pain and depression symptoms, no significant differences were observed relative to the control group. These findings were comparable with those of Sanders et al. (1997) where no significant treatment effects were determined after a brief single session CBT intervention for NCCP again delivered by cardiac nurses. Authors of both studies have highlighted the limitations of small sample sizes and recruitment difficulties, possibly due to the fact that patients found it difficult to reject a physical explanation for the cause of chest pain. As outlined earlier, previous research has suggested that individuals with MUS have a tendency to reject psychological constructs of their problems (Chew-Graham, Brooks & Wearden, Dowrick & Peters, 2011), resulting in an unwillingness to engage in psychological treatments (Shaw and Creed, 1991; Nezu, Nezu & Lombardo, 2001).

Regarding the use of metaphor therapy for NCCP after which no significant benefits were observed in terms of discomfort, anxiety or depression,(Bahreman et al., 2015; Bahreman et al., 2016), the authors suggested that the nature of the intervention itself may not be suitable given that it is dependent on an individual's ability to visualize. However, some evidence exists to support the use of this intervention, and it was a component of a group psychological intervention for NCCP included in the current review within which significant treatment effects were observed (Potts et al. 1999).

The included studies which reported significant treatment effects compared with controls after brief CBT for MUS/SSD (Escobar et al, 2007; Martin et al., 2007; Allen et al., 2006). Martin, Rauch, Fichter & Rief (2006), carried out a randomized controlled trial utilising a one session CBT intervention for patients with MUS in Primary Care. As previously highlighted, findings indicated a more marked reduction in the amount of doctor's visits and in the severity of somatization in the CBT group compared with the standard care group. Although actual treatment effects were smaller for this single session intervention when compared with more intensive CBT approaches, brief interventions still facilitate the treatment of a greater number of MUS patients. It has been suggested that brief intervention could improve the general management of MUS at the primary care level and subsequently aid access to more specialist interventions if clinically required. Furthermore, the importance of early intervention should be highlighted given that the condition becomes much less manageable and complex over time (Barsky et al., 2001). It has been suggested that a brief treatment such as a single session CBT/LICBT intervention could be an appropriate and effective first point of treatment within a stepped care approach in order to improve management of MUS. (Rief and Nanke, 2004; Martin et al., 2006).

7.4.2 Variations in outcomes

Differences in the outcomes observed in the selected studies, may be a result of variations in the components and theoretical frameworks of the interventions, the duration of the interventions, sampling issues, the selection strategies employed to recruit participants, the outcome measures used to determine MUS and psychological wellbeing, the experience levels of persons delivering the interventions, and how data was collected and analysed.

The psychological framework of the interventions evaluated in the selected studies included CBT, psychosocial, psychosomatic, relaxation, metaphor, and general group therapy. Significant effects at the post-intervention stage (at least), were reported by all included studies except 3 studies which implemented brief CBT, and 2 studies which implemented brief metaphor therapy.

However, 13 studies did determine significant effects for brief CBT, as did both studies which used psychosocial treatments. Furthermore each of the single studies evaluating either psychosomatic, relaxation or general group therapy also reported significance. It is not possible therefore to concretely conclude if one of these brief interventions might offer superior benefits to the other, given the more limited available outcomes from trials assessing interventions other than those which are CBT based. Rather, it may be concluded that some evidence exists to support the use of all of the interventions for medically unexplained symptoms and associated psychological distress, with the exception of metaphor therapy. More specifically there is substantial evidence within the current review supporting the use of brief/time-limited CBT, and existing but more limited evidence supporting the use of the remaining included interventions.

Several studies highlighted issues with sampling and sampling size, which might have influenced outcomes. Arnold et al. (2009), despite screening 6409 potential participants, could include just 65 in the trial. Some were excluded due to a natural reduction of symptoms or due to the presence of severe and comorbid conditions. Chronic issues with somatization are likely to follow a path of highs and lows in relation to the severity of and response to symptoms, much like depression and anxiety disorders, however, a majority of eligible participants declined the intervention as they had 'accepted' symptoms were part of their life.

As indicated earlier, there was a large variation in sample size in the selected studies. Eleven of the studies included 60 or fewer participants, and one study included 444 participants. Given that the power of the study may be affected by a sample which is either too large or small, it is reasonable to suppose that at least some of the included studies may have been under-powered to clearly indicate between-group differences of statistical significance (Machin et al., 2011; Button et al., 2013)

The selection of an appropriate outcome measure is an important consideration which can impact the value of results from clinical studies. Selection of measures has tended to concentrate more on the psychometric properties, but less on the actual suitability of the instruments for their intended purpose. Coster (2013) has suggested that in addition to an evaluation of basic psychometric properties, researchers should consider that different instruments may capture different aspects of complex phenomena and may therefore not be equally valid for everyone. Furthermore, a good fit between the measure and what the researcher expects to change post treatment is required to facilitate a valid interpretation of the outcomes. As indicated earlier, a considerably large variety of primary and secondary outcome measures were included in the selected studies, and it may be the case that not all of those were the optimum instruments.

The interventions evaluated in the selected studies were delivered by either therapists who had been trained specifically in the relevant interventions, GPs, clinical psychologists, or cardiac nurses. Both studies using cardiac nurses reported no significant intervention effects, and 2 of the 4 studies within which interventions were delivered by GPs also reported no significant intervention effects. Gerger, Hlavica, Gaab, Munder & Barth (2015), conducted a systematic review and meta-

analysis of randomised controlled trials of psychological treatments for MUS in which 3225 patients within 20 studies were analysed. They found psychological interventions were more beneficial when delivered by psychotherapists compared with GPs, and more specifically that psychotherapists had a greater effect on physical symptoms than GPs. An earlier systematic review (Burton, 2003) considered the prevalence of medically unexplained physical symptoms, the extent of comorbidity with psychiatric disorders, the importance of psychological processes and the effectiveness of interventions. It was reported that there was significant overlap between symptoms and syndromes, and that patients with MUS should therefore be considered as having complex adaptive systems within which cognitive, physiological and environmental factors interact. CBT and antidepressants are effective, however these benefits are heightened when patients feel empowered by their own doctors to address their problems. Burton (2003) consequently highlighted the importance of the GP role i.e. to validate the patient experience, provide positive and empowering explanations of symptoms and to offer evidence based interventions including CBT. Morris et al (2007), found that GP-patient interactions did impact consultation and communication patterns but did not subsequently impact patient outcomes.

It is also important to acknowledge that while the current review focused on time-limited intervention, the duration of the course of treatments evaluated in the included studies ranged from a single session to ten sessions, with sessions also varying in length in addition to varying times between sessions, and the point at which follow up data was collected. The potential impact of this on outcomes cannot be disregarded. In order to reach more robust conclusions regarding the confounding factors which impact clinical outcome in MUS, larger sample sizes and longer

follow –ups should be employed, given the effects of clustering and generally modest effects observed.

There are other methodological issues to consider including that there a were variety of methodologies employed in relation to data analysis. Not all of the included studies reported specifically how data was cleaned or how missing data was handled, and there is a possibility this may account for variability between outcomes.

Furthermore, some studies employed power analysis and reported effect sizes, and some did not. It is therefore recommended that any future trial addresses this methodological weakness in order to improve and determine the most effective treatment.

7.4.3 Risk of Bias

All of the included studies employed random allocation to intervention or control group, although many lacked precise details regarding how this was achieved, and the risk of bias remained unclear in several studies (see Table 7.3).

7.4.4 Strengths and Limitations

The main strength of this systematic review is the focus on brief interventions which are feasible to offer as part of a stepped care approach. A limitation is that the included studies were screened by only one author (except for risk of bias examination), increasing the possibility that a study might have been missed.

7.4.5 Recommendations for future research

The findings of the current review suggest that low intensity psychological interventions can be effective for patients with MUS,HA or NCCP. With reference to Northern Ireland, given that a need has been identified for individuals with NCCP

(McDevitt-Petrovic, Kirby and Shevlin, 2017), future research may take the form of a randomised control trial facilitating the piloting of an intervention. The first element would provide MUS/HA/NCCP patients with some type of psychoeducational material regarding the nature of anxiety symptoms. The second element would involve setting up a referral pathway from emergency department staff to the GP. The GP would then subsequently refer to the psychological therapies hub from which onward referral to the appropriate service would be made. Psychological wellbeing practitioners would likely form part of this referral pathway given the evidence base for the efficacy of low intensity CBT for health anxiety.

7.4.6 Conclusion

The evidence suggests that brief psychological interventions, more specifically time limited BCT based interventions may have small to large effects in reducing the severity of MUS and associated psychological distress. These findings are comparable with other reviews which have assessed the efficacy of higher intensity and/or longer term interventions. Given that there is a broad range of symptom severity and willingness to engage in psychological treatments among MUS patients in primary care, it is reasonable to suggest that a stepped care approach may be suitable thereby facilitating a more specialist intervention in chronic cases (Looper & Kirmayer, 2002; Smith et al., 2003). However, there remains a need to provide more robust evidence of cost effectiveness in relation to mild and moderate cases (Williams, 2014) for which briefer interventions such as those evaluated here, tend to be recommended.

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Chapter 8

Discussion

Chapter Overview

The purpose of the current chapter is to firstly reiterate the overall objectives and outcomes of the project (i.e. all empirical chapters), and subsequently to discuss the findings in the context of their wider impact and implications. This chapter will also consider the limitations of the current project before outlining the resultant clinical and practical research recommendations and conclusions.

8.1 Thesis research questions and outcomes

The main aim of the current thesis was to evaluate a new psychological therapy service in Northern Ireland (NI), designed to treat adults with mild to moderate level mental health difficulties, primarily depression and anxiety. The particular mental health service model which was implemented and subsequently evaluated in the current study, was designed and delivered in accordance with the English “Improving Access to Psychological Therapies” (IAPT) service model. This service facilitates the delivery of low intensity cognitive behavioural therapy (LI-CBT) by psychological wellbeing practitioners (PWPs). Evaluations of this new service model in NI were presented in Chapters 3-5. As previously explained, the English IAPT initiative has also recently focused on developing services for individuals with mental health difficulties who have comorbid medically unexplained physical symptoms (MUS/MUPS) or long term physical health conditions (LTC). A recently

published document by NHS England ‘Implementing the Five Year Forward View for Mental Health’ (NHS, 2016) describes a commitment to achieve parity of esteem for mental and physical health, with expectations that by 2020/21, an additional 600,000 individuals will access IAPT services, two thirds of whom will have coexisting physical health issues. The purpose therefore of subsequent chapters (6 and 7), was to consider if such service developments might also be usefully implemented in NI.

8.1.1 Evaluating reliable symptom change

Rates of reliable symptom change, specifically improvement, deterioration and recovery were determined in relation to both symptoms of depression and anxiety. Outcomes were derived from data collected from patients (N=253), treated by the 2014/15, 2015/16 and 2016/17 cohorts of trainee PWPS. PHQ-9 and GAD-7 scores were collected at every session. In keeping with IAPT recommendations, clinical outcomes reported here relate only to patients who met caseness criteria. As described in Chapter 3, this requires that a patient has seen the PWP at least twice, (at least 2 treatment scores are necessary in order to calculate any measurement of symptom change), and that they have scores which are above the thresholds for clinically relevant symptoms on at least one of the psychometric measure at baseline (specifically 10 or above on the PHQ and or 8 or above on the GAD). In relation to depression, 59.7% of clients achieved reliable improvement and reliable deterioration was determined in 2.8%. Reliable improvement and deterioration rates of 73.9% and 4.3% respectively, were determined for anxiety symptoms. Overall reliable deterioration at the end of treatment was observed in 5.2% of clients, and overall reliable improvement was achieved by 77.9% of clients. The criteria for

overall reliable recovery was met by 51.6% of case clients. When these clinical outcomes were compared with national IAPT findings for 2017, there was no proportional difference observed in overall reliable recovery rates between clients treated in NI and those treated in England at the same time period [$\chi^2(1, N = 211) = 1.79, p > 0.1$]. However, the proportion of clients treated in NI who demonstrated overall reliable improvement was significantly higher when compared with rates in England, [$\chi^2(1, N = 211) = 15.21, p < 0.001$]. Furthermore, the longer term effectiveness of the treatment was examined by determining how rates of reliable change in symptomatology may or may not have been maintained at a four month follow up point after the end of treatment. The sub sample completing measures for follow-up was small, however the findings derived from analysis of the data obtained indicated that of 26 clients who achieved overall recovery at treatment end, 24 still met this recovery criteria at the follow-up point. Furthermore, 9 clients who had not achieved recovery criteria by the end of treatment subsequently met the criteria at the four month follow-up, supporting the case at least, for the feasibility of a larger and more robust follow-up evaluation.

It may be concluded that evaluations of reliable symptom change within the sample have provided preliminary quantitative evidence for the clinical effectiveness of LICBT delivered by trainee PWPs targeting mild to moderate level depression and anxiety in NI.

8.1.2 Examining LICBT treatment response

The purpose of the subsequent arm of the evaluation was to model changes in anxiety and depression during LICBT and to investigate which individual or service level variables might be predictive of treatment response. Growth mixture modelling (GMM) techniques were employed to examine changes in anxiety and depression among clients (N=253) over the first six sessions of treatment in order to determine divergent early response trajectories. Several pre-treatment variables were used to predict latent class membership using Chi-Square tests and binary logistic regression models. There was one class representing improvement and one representing no improvement for both anxiety and depression, and membership was predictive of treatment outcome. Pre-treatment variables associated with less improvement included unemployment, risk of suicide, neglect of self or others, using medication, receiving previous or concurrent treatments, a longer duration of difficulties, and comorbidities. It may be concluded that these quantitative outcomes provide further evidence for the clinical effectiveness of LICBT delivered by trainee PWP given that the majority of the sample populated the ‘improvers’ class for both depression and anxiety. Pre-treatment variables identified as predictive of poor treatment response have furthermore highlighted potential exclusion criteria with regard to client suitability for LICBT.

8.1.3 Investigating the perspectives of PWP service providers

Qualitative research was also carried out in order to explore the perspectives of service providers in regard to how the PWP service may or may not have improved access to psychological therapies in NI, and to investigate their experiences of and feelings about mental health services generally in NI using interpretative

phenomenological analysis (IPA). Emergent themes extracted from the transcripts, were categorised under two headings, namely attitudes towards the PWP service and attitudes to services overall in NI. Further analysis led participants' experiences to be clustered around three superordinate themes, specifically, benefits of the PWP service, improving the PWP service, and challenges for future service provision in NI. From each of these, several subordinate themes were identified, namely clinical effectiveness and filling a gap in service provision in relation to the perceived benefits of the service, and increasing awareness, and increasing availability in relation to how the service could yet be improved. Three subordinate themes emerged in relation to challenges for future service provision in NI, namely attitudinal barriers, systematic barriers and hope for positive future change.

It may be concluded on balance, that these qualitative findings corroborate the earlier quantitative evidence, thereby supporting the case that LICBT as delivered by PWPs in NI is a clinically effective service. However, as noted and discussed in Chapter 5, a number of current and potentially future challenges were highlighted, particularly in relation to availability and utilization, and indeed in regards to the current status of mental healthcare services generally in NI.

8.1.4 Investigating the prevalence of non-cardiac chest pain

Finally the project contemplated how LI-CBT interventions could be delivered to other suitable patient populations in NI, specifically those with medically unexplained symptoms and associated anxiety. Administrative data was analysed in order to assess the number of chest pain admissions to an ED department and the subsequent counts of NCCP over a 3 year period in an urban hospital in NI, and the likelihood of NCCP based on admission with chest pain was estimated. The most

common non-cardiac diagnosis each year was 'Chest pain of unknown cause' (33.8 - 40.2%), with a relatively small number of diagnoses of 'anxiety' (1.3 - 2.4%) or 'panic' (.5 - .75%). When all 3 years were combined 8295 (4.6%) of initial presentations were chest pain, and 135 (24.4%) and 54 (24.5%) were anxiety and panic diagnoses respectively following an initial presentation of chest pain. Over half ($n = 3156$, 64%) of diagnoses indicating 'chest pain of unknown cause' followed an initial presentation of chest pain. The chi-square tests showed that presenting with chest pains and receiving a diagnosis of panic, anxiety, or CPUC were significantly associated. In total, 3345 (58.7%) of all the non-cardiac diagnoses (anxiety, panic and chest pain of unknown cause) followed an initial presentation with chest pain, and this association was statistically significant ($\chi^2 (1) = 39,263.76$, $p < .001$). It may be concluded that these findings have highlighted a need among this particular patient population for whom the pathways to appropriate care are very unclear. Hence it was suggested that a review of potential treatment options should be carried out.

8.1.5 Are brief and low intensity psychological interventions effective for medically unexplained symptoms?

A subsequent systematic review examined brief or low intensity psychological interventions which may be suitable for this and similar sub-populations of patients. A total of 23 studies were included in the final synthesis. Significant effects for intervention groups relative to control groups were reported in 19 studies, whilst 4 studies did not determine any significant benefits of interventions compared with controls. All of the brief interventions (CBT, psychosocial, psychophysiological, psychosomatic, relaxation and group therapy), with the exception of metaphor therapy, showed significant effects relative to controls in at least one study. It may be

concluded these findings corroborate evidence that brief psychological interventions, more specifically time limited CBT based interventions may be effective in treating HA and MUS with psychological distress and should be considered for provision within a NI population.

8.2 Discussion of overall findings: Implications and impact

8.2.1 Evidencing an effective service

The English IAPT initiative was developed as a systematic way in which to organise, develop and improve the delivery of and access to evidence based psychological interventions within the NHS in England, and it has been heavily influenced by both clinical and policy developments. The nationwide implementation of the programme in 2008 was a result of two successful pilot sites in 2006, and this has since transformed the treatment of common mental health difficulties, primarily depression and anxiety disorders. It is estimated that approximately 950000 individuals access IAPT services annually with 50% of these achieving reliable recovery and two thirds achieving reliable clinical improvement (NCCMH, 2018). As outlined in ‘The Five Year Forward View for Mental Health’ the UK government has committed to expanding IAPT services by facilitating access for an additional 600, 000 individuals by 2020/21, which will require recruiting 4500 more clinicians, 3000 of whom will work within primary care level services. It is reasonable to suggest that mental health services in NI and those responsible for implementing organisational and operational changes can learn from how care has been transformed in England, particularly given that evidence now exists to support the clinical effectiveness of the model in a NI population (McDevitt-Petrovic et al., 2018). As widely discussed throughout the project, there remains a lack of a functioning stepped care model in NI (Blane,

Williams, Morrison, Wilson & Mercer, 2014). It has been established that we require more low intensity practitioners in NI to address this (HSC, 2014; DH, 2016).

Current findings indicate that PWP's have addressed this need, and can occupy the identified gap in service provision, facilitating earlier intervention for mild to moderate level difficulties.

Qualitative research findings reported in Chapter 5 provide evidence for the clinical effectiveness of the NI PWP service which was described as “invaluable” and “excellent” by service facilitators. Moreover all participants inferred that the current gap in service provision (at Step 2) was addressed, describing the PWP service as “a great resource” which was missed when trainee PWP's were not on placement. This is corroborated by previous evidence suggesting the provision of low intensity services is associated with relieving pressure on the workloads and waiting lists of other clinicians (Chan & Adams, 2014; Clark et al., 2009).

Service users have provided “great feedback” to service providers according to several participants of the qualitative study. Such feedback is crucial for service improvement (Coulter, Locock, Ziebland & Clalbrese, 2014). Current qualitative research in relation to clients’ experiences in IAPT is relatively limited, hence a recommendation for further investigation of service user experience in relation to PWP's has been made.

The usefulness of sessional routine outcome monitoring which facilitated the collation of rich data must be acknowledged in relation to the current evaluation; it is the first study in NI, to evaluate a talking therapies service in such a robust way, providing a significant contribution to the evidence base for LICBT. In regard to continuation and development of a PWP service in NI, it would be useful to continue

collecting data in this way, in keeping with IAPT protocol. Furthermore routine outcomes measures (ROMS) can enhance treatment fidelity (Schoenwald et al., 2011), and they are a crucial means of validation and stimulate continuing government funding by enabling IAPT services to robustly demonstrate their clinical effectiveness (Seward & Clark, 2010).

The nationwide routine collection of data from all services therefore serves as a form of systematic audit allowing the IAPT programme to formulate an overview of treatment access, engagement and outcomes which can be subsequently used to rank services (Clark et al., 2009; Delgadillo et al., 2014; Glover et al., 2010; RCP, 2013). It has been suggested however that data analysis may be somewhat limited by high levels of heterogeneity and inadequate knowledge regarding the impact of case diversity on outcome (Delgadillo et al., 2014).

ROMS are also regarded as diagnostic tools based on their symptom checking functions, although these characteristics have added to the criticism of their use within IAPT, with specific suggestions that they endorse a biomedical perspective of common mental health difficulties (Loewenthal, 2015; Marziller & Hall, 2009; Rizq, 2012). However, ROMS are also intended to enhance the clinical judgement of practitioners; use may be resisted somewhat due to practitioner's feelings of anxiety about their skills being monitored or feelings of disempowerment (Rizq, 2012; Steel et al., 2015; Walklet & Percy, 2014). It has been found that some practitioners perceive ROMS to be restrictive, narrow, burdensome, disruptive and not clinically useful (Boswell et al., 2015; Unsworth et al., 2012). It is important therefore that PWP's (both trainees and qualified), appreciate the importance and purpose of their use (Wolpert, 2014); some evidence suggests the benefits of ROMS are not always or fully understood among practitioners (Gellatly, 2011; Lucock et al., 2015). This

was considered carefully in relation to the current evaluation, and all trainees were fully aware of the important function of ROMS. Good quality and regular supervision is also helpful in relation to overcoming resistance about particular procedures such as the collection of ROMS (Boswell et al., 2015; Lucock et al., 2015; Unsworth et al., 2012), and can help trainees and practitioners effectively manage caseloads (Unsworth et al., 2012). Specifically in conjunction with regular case management supervision, the information gathered from the collection of ROMS can enhance service efficiency and workforce time management, given that practitioners may be challenged about continuing to treat clients perhaps unnecessarily when their scores have reduced sufficiently or are no longer clinically relevant (Delgadillo et al., 2014, 2015).

The evidence provided within the current project supporting the effectiveness of the NI PWP service, could not have been produced without the use of ROMS, and furthermore as suggested by previous research they were an integral component of clinical supervision, and aided trainees in relation to adhering to a stepped care framework.

Specifically, quantitative findings presented in Chapters 3 and 4 indicate that favourable rates of reliable recovery and improvement have been determined, and moreover longitudinal analysis indicates the majority of clients populated a latent class of 'improvers' in relation to both depression and anxiety symptoms after 6 sessions, with several important predictors of treatment response identified.

Outcomes derived from follow-up data indicated that reliable improvement was maintained in 79.9% of cases, and overall reliable recovery in 53.3%. These are favourable compared with a similar recent follow-up study (Ali et al., 2017). Whilst

the current sample was significantly smaller, with a follow up duration of 4 months as opposed to 12, Ali et al. (2017) also determined that 80% of relapses occurred within the first 6 months. Therefore the promising outcomes from NI should not be discounted and moreover the feasibility of conducting a larger follow-up evaluation should be recognised. Depression and anxiety disorders at any level of symptom severity can be recurrent and chronic, and psychological therapies can help reduce the likelihood of recurrence given that individuals acquire skills which they can use in the future, in order to reduce the impact of stressful life events and situations which become emotionally challenging. Within IAPT, the longer term effectiveness of interventions has had mixed results. Initial evaluations concluded that treatment gains after LICBT were largely maintained at 4-13 month follow ups (Clark et al., 2009), but as highlighted previously this was not replicated for one site more recently (Ali et al., 2017). A number of strategies have been suggested in order to prevent recurrence and relapse which could also be considered for services in NI. (NCCMH, 2018). Specifically, practitioners have been advised to focus on ensuring that patients have learned and acquired skills for overcoming emotionally challenging situations in addition to achieving recovery criteria. Some patients, in particular those with mild to moderate depression might recover throughout the course of treatment without learning any useful skills because they were going to recover within this period of time anyway (natural recovery). Such patients may be more likely to relapse unless their therapist has ensured the necessary skills have been acquired (NCCMH, 2018). It is also important to develop a relapse prevention plan with patients before they are discharged and to possibly schedule one or more follow up appointments three to six months after treatment. Such follow up sessions can be an effective way of identifying early signs of relapse which may then

subsequently be effectively treated with a brief therapy booster session before the problem becomes more complex. Recently it has been posited that IAPT services might use mobile applications to collect follow up information whereby patients complete measures at regular intervals throughout the 12 months after treatment completion. The app would also facilitate access to their individualized relapse prevention plan and enable them to schedule booster sessions if required (NCCMH, 2018). The current study did not facilitate booster sessions prior to the collection of follow up data, however the recommendations mentioned above could be considered for future longitudinal research and service developments.

Recent research has revealed that clients treated by qualified PWPs compared with trainee PWPs have better clinical outcomes (Branson, Myles, Mahdi & Safran, 2018). Given that the outcomes reported in the current evaluation pertain to trainee practitioners, it is reasonable to suppose that evaluations relating to qualified PWPs in NI would be at least as promising, if not potentially more promising than the current outcomes.

8.2.2 Expanding services for MUS

The current study has also identified a significant need among patients with non-cardiac chest pain in NI (McDevitt-Petrovic et al., 2017). Regarding the impact of depression and anxiety disorders on healthcare services, it has been estimated that costs for those with physical health problems and coexisting mental health difficulties are up to 50% higher (Pooler & Beech, 2014), although a considerable percentage of this is attributed to the increased use of physical as opposed to mental health services (Layard & Clark, 2014). It has been determined however, that individuals with MUS who are not offered psychological intervention as part of their

care have more primary care contacts than those who are (Knapp, McDaid & Parsonage, 2011; Allen, Woolfolk, Escobar, Gara & Hamer, 2006). Similarly for those with a long term physical condition, a higher number of acute and emergency care contacts have been determined (Howard, Dupoint, Haselden, Lyneg & Wills, 2010). Overall, it has been found that frequent attenders account for 45% of all primary care contacts and 8% of all emergency care contacts (Burton, McGorm, Richardson, Weller & Sharpe, 2012; Konnopka et al., 2013). Depression and anxiety can impede self-care and self-management of LTCs resulting in further complications increased disability, decreased quality of life, increased risk of mortality and increased use and costs of healthcare services (Lin et al., 2010; Edege & Ellis, 2010).

As previously discussed, IAPT services are working towards increased and improved provision for those with comorbid physical and mental health difficulties. Wroe, Rennie, Gibbons, Hassy and Chapman, (2015), carried out service development pilot work which aimed to develop an effective intervention deliverable at Step 2 by PWP's for individuals with Type 2 diabetes. Standard LICBT met with challenges when delivered to this patient population, however an apparently tailored version resulted in significantly improved physical and psychological symptoms. For the IAPT services currently targeting LTCs and MUS, adherence to the stepped care model will be maintained with 30% of the workforce as PWP's, 60% high intensity therapists and 10% senior practitioners such as clinical and health psychologists who can treat more complex problems and supervise others. (NCCMH, 2018).

There is no research evidence to date reporting specifically on the prevalence of MUS among patients in NI, highlighting the importance of the needs analysis presented in Chapter 6. Outcomes are consistent with previous research findings that

a significant proportion of patients presenting to ED with chest pains were subsequently given a non-cardiac diagnosis (also highlighting common links between physical and mental health). It is important to note that although not much is known about the long-term economic implications of NCCP, studies to date have suggested that costs are likely to be substantial (Eslick & Talley, 2004; Mourad et al., 2013). In addition it has been reported that NCCP patients use out-patient services to the same extent as those with cardiac diagnosis (Beek et al., 2013). Previous research also highlights that these individuals do not function particularly well, specifically enduring depression, anxiety, persistent unexplained pain and loss of employment (Shah, Kataria & Tanna, 2015).

As discussed previously, anxiety has also been found to be very poorly detected within ED and even where it is, appropriate interventions are not often implemented (Dammen et al., 2006; Foldes-Busque et al., 2012; Wulsin et al., 2002). It may be reasonably suggested that anxiety might also have been poorly detected given the relatively low proportion of anxiety diagnoses compared with ‘chest pain of unknown cause’ (McDevitt-Petrovic et al., 2017).

As discussed, LICBT has been found to be clinically effective for NCCP and comorbid psychological difficulties (Beek et al., 2013; Lessard et al., 2012; Jonsbu et al., 2013). Facilitating access to this treatment must be considered for this patient population in NI. As a result of this needs analysis, two nurses have been employed and assigned specifically to assist those identified as having non-cardiac chest pain, although referral pathways to psychological care remain unclear.

The rationale for the systematic review presented in Chapter 7 related firstly to the needs identified in Chapter 6 and the lack of clarity on referral pathways for patients

with NCCP, and secondly, related to the lack of current reviews focused solely on brief or low intensity interventions.

It is important to note that the effectiveness of LICBT was evidenced in the outcomes of the systematic review, and also that it was more efficacious when delivered by trained psychologists or practitioners as opposed to GPs or nurses. More robust evidence is needed as to how we can successfully incorporate this into a stepped care model with appropriate referral pathways, and in relation to how we can increase acceptance of and willingness to engage in psychological treatments, among patients with MUS and associated depression or anxiety.

8.2.3 Improving access to timely and appropriate care

It is important to be clear about which patients may be suitable for, and therefore more likely to benefit from a PWP service in NI, and to reinforce the relevance of inclusion and exclusion criteria. As discussed in Chapter 4, it is important to consider that an intervention which has been evidenced as clinically effective, may not always be the optimum treatment for all patients (Howard, Moras, Brill, Martinovich & Lutz, 1996). There is an important need to identify which individual level variables may predict treatment outcome. If we are to develop a LICBT/PWP service in NI, then it is imperative treatments are offered to the correct people. Findings reported in Chapter 4 offer further evidence for the clinical effectiveness of LICBT in NI, with the majority of clients populating an ‘improvers’ class, as opposed to a ‘non-improvers’ class for both depression and anxiety. To our knowledge the research presented in Chapter 4 is also the first UK based work which has employed growth mixture modelling techniques to determine predictors of treatment response, following LICBT delivered by PWPs. These findings provide

essential information with significant clinical implications for initial referrals and assessments, reinforcing the importance of providing an individual with the right treatment, at the right time, delivered in the right place, by the right person.

As discussed further in Chapter 5, improving access requires more than clinical effectiveness; is a clinically effective service truly effective if is not adequately accessible? In relation to the awareness, acceptability, availability and utilization of services, qualitative outcomes were not so promising, with reports that, regarding PWP, “no one knows them or what they do” and additional observations that “access is still pretty difficult.” The fact that referrals still frequently wait too long as reported by service providers, increases the chances of problems becoming more complex and chronic, and moreover increases the likelihood that a client may no longer be suitable for low intensity treatments by the time they are actually seen (Dell’Osso, Glick, Baldwin & Altmura, 2013). Specifically it was observed that “some of the referrals we see here are bad because of the delay in access.” Research has established that longer waiting times are associated with poorer treatment outcomes, subsequent non-attendance, poor engagement and discontinuation (Dell’Osso, Glick, Baldwin & Altmura, 2013; Gallucci, Swartz & Hackerman, 2005; Jackson, Booth, Maguire & Salmon, 2006), and indeed the outcomes reported in Chapter 4, determined those with longer term difficulties were less likely to demonstrate improvement of depression and/or anxiety symptoms.

The need to increase awareness and acceptability of the service is highlighted further by earlier research which has determined that patients who agree with and understand their referral are more likely to attend appointments than those who don’t (Killpsy et al., 2000). Poor awareness of services, particularly those which are relatively new, is common; as suggested by the outcomes reported in Chapter 5, it is

essential that we work to increase awareness and to strengthen links with the community and voluntary sector (Turner, 2015; Savage et al., 2015).

As observed by several service providers, there remains “no clear pathway on how you can access PWP services in NI.” In relation to the current pathways to care, it was suggested that it “would be really great if there was a way for the client to self-refer”, and moreover that “if GPs could refer directly, it would improve access”

The challenges for future mental health service provision in NI were strongly represented within the qualitative data. In particular this was conveyed through frustration at the lack of a functioning government and consistent interprofessional difficulties in the mental healthcare sector.

All of these emerged as perceived significant barriers to further improving access, as did ongoing issues regarding stigmatisation. Specifically, stigma was highlighted as a barrier to help seeking in keeping with previous evidence (Gulliver et al., 2010), and was also referred to as a barrier to treatment engagement and continuation, similar to previous research findings (Pescosolido et al., 2010); “theres is still a certain stigma to them coming here to these appointments”

Attitudinal barriers among healthcare workers were described as “interprofessional difficulties.”: similar difficulties were apparent in the early stages of IAPT, and this required significant relational work in order to transform service provision (Altson et al., 2014; Lewis, 2012). Involving the workforce in the design and implementation of new services is associated with subsequently higher levels of job satisfaction and improved staff retention (Boswell et al., 2015; Wolpert, 2014), and so it may be suggested that awareness of the PWP service must also increase among service

providers who do not currently facilitate clinical placements for trainees, but who may benefit from this, or from employing qualified PWPs at their site.

The effective development of local care pathways achieved by the collaborative work of commissioners, primary and secondary care practitioners, patient groups and community organisations is essential in relation to improving access to services, particularly for underrepresented and minority groups (NICE, 2011). As our communities in NI became increasingly diverse it is crucial that services have bilingual therapists, appropriately trained interpretations and practitioners who are fluent in British and Irish sign languages. Continuing professional development is also critical in order to increase capacity and enhance competence within the workforce particularly around cultural competencies.

In relation to how a modified workforce might look in NI (to include the recommended increase in low intensity practitioners), it is useful again to consider the IAPT workforce; it is recommended that within a core IAPT service, 40% of the workforce should be PWPs and 60% should be high intensity practitioners. It has been suggested, that generally the IAPT programme has also significantly benefited from having National standards and targets in place. However, under poor clinical leadership, such targets can become discouraging and onerous; when guided by strong leadership they can foster an innovation environment. Again, the importance of strong clinical leadership when contemplating service reform in NI should be regarded. It is clear from qualitative outcomes, that service providers are frustrated by inadequate communication, poor decision making, lack of collaboration and interprofessional difficulties. In 2015, NHS England held an event attended by 12 of the better performing IAPT services, after which they identified features which helped achieve excellence. All of these services were under good clinical leadership,

whereby the emphasis was on patient recovery and staff were interested in understanding outcome data as a tool for improving their own clinical work. A specific example of such data-driven practice has been outlined in the ‘Plan, Do, Act’ protocol (Pimm, 2016), which is now undertaken in a number of IAPT services. This involves reviewing all available information on patients who did not achieve recovery criteria (for a relatively short period of time, e.g. one month). The subsequent information gathered from such a review then enables service providers to consider what could have been done in order to change this. These suggested changes are then implemented and evaluated. Pimm (2016) reported an increase in recovery rates from a mid-40s percentage range to a mid-60s percentage range after following this procedure, and several other services have reported similar positive outcomes.

It is also essential to acknowledge that the low intensity treatments provided in the current evaluation, were delivered face to face, although telephone sessions were optional. Low intensity treatments can be more accessible with increased flexibility; there is not yet an option for instance, to attend a PWP in NI within a group session. NICE also recommends group work (multiple sessions, and never a single session), for mild to moderate level symptoms whereby an appropriately trained PWP delivers information on LICBT and psychoeducation.

Another development in treatment delivery yet to be considered for PWPs in NI, relates to interventions which are digitally enabled. In this case, the majority of learning can be achieved by working through materials and resources online. Importantly however, this also requires ongoing contact with a therapist (for example via secure messaging or telephone), in order to enhance motivation, provide encouragement, and to address any difficulties thereby enhancing understanding of

CBT techniques and resources. Patients should always be given a choice between digital and non-digital therapies.

Thornicroft (2018) furthermore suggests the range of evidence based therapies provided by IAPT services should be expanded. Meadows and Kellett (2017) agree and suggest specifically that there is a lack of treatment flexibility at Step 2 of IAPT services, delivered by PWP's. In relation to tailoring higher intensity models of care to make them workable for step 2, some preliminary research has been carried out, Specifically Lemma and Fonagy, (2013) carried out a controlled trial of online group dynamic interpersonal therapy which suggested the intervention, whilst only evaluated on a small sample, was feasible. Meadows and Kellett (2017) developed and subsequently evaluated the efficacy of a cognitive analytic informed guided self-help treatment for mild to moderate level anxiety disorders for delivery by PWP's. Cognitive Analytic Therapy (CAT; Ryle, 1995) is described as a relational approach to mental health which focuses on collaborative identification of problematic patterns in relationships which are considered to develop as a consequence and modelling of early experiences (Ryle & Kerr, 2002). Reviews to date support the efficacy of the intervention, mainly with personality disorders (Calvert and Kellett, 2014; Ryle, Hepple & Calvert, 2014) although recommendations have been made to investigate the potential benefits of the treatment for depression and anxiety, and indeed in a lower intensity (Calvert & Kellett, 2014).

A low intensity version of the intervention as evaluated by Meadows and Kellett (2017), met the target quality parameters for guided self-help. There was a high treatment completion rate, with 10/11 participants finishing, with 6 of these subsequently achieving reliable recovery criteria at follow-up. They concluded that CAT-SH has demonstrated promise as a LI intervention for anxiety, and that larger

evaluations facilitating control groups are warranted. As formerly discussed, the evidence base for low intensity interventions targeting depression and anxiety disorders, focused largely on the cognitive behavioural model which is easily applied to guided self-help formats (Turpin, 2010).

As formerly highlighted, in addition to clinical effectiveness, the acceptability of interventions is another important feature of the evidence base (Meadows & Kellett, 2017). It has been posited that the relatively high treatment dropout rates reported for PWP treatments at step 2 (Chan & Adams, 2014), may be associated with lower acceptability of LICBT based interventions (Milosevic et al., 2015). Given that treatment completion is a strong predictor of overall outcome (Cahill et al., 2003), it may be reasonable to suggest that patients should be offered a broader range of treatments at step 2 in order to potentially boost rates of treatment engagement, retention and completion (Meadows & Kellett, 2017).

A choice of treatments is recommended for individuals experiencing depression and anxiety (CSIP, 2008; NICE, 2009), and indeed interventions offered at Step 3 within IAPT services do include interpersonal psychotherapy (IPT), brief dynamic interpersonal psychotherapy (DIT), counselling (for depression), and couples counselling, all of which have separate IAPT competency frameworks.

Recent research findings have furthermore highlighted a ‘therapist effect’, specifically indicating that some PWPs routinely deliver LICBT interventions more effectively (Green et al., 2014; Poeria et al., 2016) and more efficiently (Firth et al., 2015), suggesting it is much more than a mechanical intervention. Pereira, Barkham, Kellett & Saxon, (2017) specifically found more effective PWPs demonstrated comparatively higher levels of both mindfulness and resilience.

An important feature of the PWP role is the requirement to liaise with third party organisations and reemployment advisors, particularly within the community and voluntary sector (Richards & Whyte, 2011). Indeed given that current thesis findings determined unemployment to be a predictor of non-improvement, this aspect of the PWP role should be emphasised further. It may be reasonable to suggest that a PWP already operates as a kind of social prescriber, in addition to providing LICBT. One service facilitator who participated in the qualitative arm of the current evaluation, employed the trainee PWP as part of a social prescribing model, and referred to this as being “100% effective”. In relation to psychological wellbeing, social prescribing (SP) has been endorsed as an extremely beneficial way in which social difficulties can be effectively managed for those with comorbid mental health difficulties (Friedli, Jackson, Abernethy & Stansfield, 2013).

It has been widely reported that integrated care is preferred by individuals who access a number of different services, and achieving this is one of the more prominent challenges currently within the NHS (NHS 2016; NCCMH 2018). It is often difficult to provide person centred care which is coordinated to meet physical, mental and social needs, and this frequently results in increased distress for those requiring multiple services (Naylor, Taggart & Charles, 2017). It has been suggested therefore that the IAPT programme should be commissioned a part of a wider systems approach whereby local services are developed by collaborating with service users and their care givers at all stages. By embedding IAPT services within local care pathways, referral and stepping (up, down or out) protocols are more clear, and services are therefore better placed to ensure people achieve positive treatment outcomes (NCCMH, 2018).

Social prescribing itself is a vital part of working as per a wider systems approach and provides individuals with this crucial link to a network of non-medical support to clients within their own communities. The NICE guidelines pertaining to psychological interventions also advocate a number of social prescribing activities, namely facilitated self help, personal skills development, bibliotherapy and digitally-enabled therapy. Social prescribing provides an important support for the provision of IAPT services by expanding access to a wider range of psychosocial interventions, increasing the variety of service providers, increasing involvements of the community and voluntary sector and increasing the capacity of services to intervene at an earlier point (NICE, 2011; NCCMH, 2018). It may be suggested that enabling PWP in NI to socially prescribe, could facilitate improved working within a wider systems approach.

8.2.4 Challenges and criticisms of the IAPT method

Although the operation of IAPT services are likely to have contributed to improved access to interventions for adults with common mental health problems (McManus, Bebbington, Jenkins & Brugha, 2016), the longer term objective for all mental health services should be to demonstrate significant reductions in the overall prevalence of mental health difficulties (Jorm, Patten, Brugha & Mojaba, 2017; Thornicroft, 2018).

The importance of increasing both supply and demand in relation to mental health care has been emphasised; more precisely it is useful to consider that a failure to treat many individuals with common mental health problems is not only due to inadequate availability of services but also due to low rates of help seeking (Thornicroft, 2018).

Many individuals identified as having common mental disorders do not receive treatment, and it has been suggested that reducing this ‘treatment gap’ would simultaneously reduce the overall population prevalence of such disorders (Andrews et al., 2004; Kohn et al., 2004), and furthermore facilitate an economic return on investments made (Chisholm et al., 2016). Jorm, Patten, Brugha & Mojtabai, (2017), evaluated the effects of reducing such a treatment gap in four countries namely Australia, USA, Canada and England between 1990 and 2015. They concluded that the prevalence of anxiety, depression and associated symptoms has not decreased despite the increased availability and provision of several interventions including particular antidepressant medications. The authors noted there is some, albeit limited evidence to suggest this outcome may be partly explained by an increase in help-seeking. The authors reported the most robustly supported explanation for this finding, is that a lot of treatment fails to meet minimal standards of practice and moreover, does not target or reach those with the greatest need (Jorm et al., 2017). Importantly they also highlighted the need for improved preventative measures in relation to common mental health difficulties, suggesting the existing lack of these may also account for failures to reduce the treatment gap (Jorm 2014; Jorm et al., 2017).

As emphasised within the current thesis, the prevalence of mental health difficulties in NI is greater than in any other region of the UK (Betts & Thompson, 2017). Surely there is an urgent need to address the treatment gap, and to increase efforts towards realising the many recommendations that have been made to improve access. It is reasonable to suggest that facilitating a PWP service would be a useful step in the right direction (McDevitt-Petrovic et al., 2018).

As alluded to by the above reports (Jorm 2014; Jorm et al., 2017), the IAPT initiative has not evaded criticism, and a number of challenges remain. It is important therefore to also consider these in terms of the implications they might also have for future mental healthcare service plans and provision in NI.

IAPT has been criticised by some for what has been described as a reductionist approach derived from the biomedical perspective of mental health care (Guy, Lowenthal, Thomas & Stephenson, 2012; Marziller & Hall, 2009; Pietroni et al., 2012; Williams, 2015). Some criticisms of the high volume, quick access approach claim it has resulted in the “industrialisation of psychological therapies” (Barrett, 2009 p. 132), and that it weakens client narrative in order to maximise service provider efficiency (Williams, 2015).

Moreover it has been suggested that that low rates of stepping up indicate a failure to identify complex cases early (Delgadillo et al., 2013; Glover et al., 2010; Richards et al., 2012; Radhakrishnan et al., 2013). Other reports have raised concerns regarding inadequate therapy doses and suggest that the focus on high volume results in some clients being offered inappropriate treatment, potentially leading to disengagement and reduced improvement or recovery (Cairns, 2014; Di Bona et al., 2014; Glover, Webb & Evison, 2010; Richards & Borglin, 2011).

Haarhoff and Williams (2017) discussed some of the criticisms of IAPT and the emphasis on the CBT model. It is the view of some that the CBT model is favoured as the principle framework of care as it facilitates the measuring of symptoms, behaviours and treatment outcomes. Practitioners working on other treatment modalities have described feelings of exclusion (Lewis, 2012; Risq, 2012). In relation to LICBT, Telford and Wilson (2010), who are PWPs themselves outline

several perceived challenges to the provision of LICBT interventions. Firstly they described dealing with negative responses from other and higher intensity mental health practitioners concerning lower intensity interventions, and with regards to PWP competence in conducting initial assessments. As mentioned earlier, therapists from other modalities have reported feeling alienated, suggesting that those adhering to the CBT model are somewhat privileged (Lewis, 2012). It has been suggested that concerns about the CBT model itself, and about the PWP assessment are due to beliefs that the model; is too simple and assessments too manualised. As a consequence, more comprehensive formulations are not always facilitated (Haarhoff & Williams, 2017). Telford and Wilson (2010), suggest that there is fear among higher intensity therapists, that PWPs could undermine their place in the workforce and possibly displace them.

In addition, it has been highlighted that the economic rationale for the implementation of IAPT, more precisely that it should “cost nothing” depends on achieving the specified target patient recovery rate of 50% in the long-term, and that failure to meet this, would compromise the economic argument (Marks, 2018). Marks (2018) has posited that the issue of long term recovery rates within IAPT will remain vulnerable to speculation without an independent and robust examination. Viola and Moncrieff (2016) reported that mental health disorders have become the most common reason for receiving benefits in the UK. More specifically, they noted an increase of 13% in relation to the number of claimants between 1995 and 2014, with consistent annual increases since 2007 corresponding with the implementation of IAPT. Conversely, the number of claimants with condition other than mental health disorders reduced. More recently however, Springer et al. (2018) conducted a meta-analysis which examined studies of remission after CBT for anxiety disorders,

and determined an overall post –treatment remission (clinical recovery) rate of 53% which increased to 56% at follow-up.

Another issue which potentially causes recovery rates to be misrepresented is the use of psychotropic medication(s); arguably, this confounds the accurate calculations of recovery rates which may be attributed to psychological intervention without the aid of medication(s). Findings from the NI evaluation, however determined the use of psychotropic medication to be predictive of membership of the non-improvers' class for both depression and anxiety. It can be tentatively suggested that medication use itself indicates the possibility of a more enduring and complex difficulty – indeed comorbidity and a longer duration of difficulties were also found to be predicative of non-improvement. The effects of medication on symptom change during therapy warrants further investigation within a NI patient population.

Marks (2018) has proposed that a longitudinal study investigating recovery rates would facilitate the separation of various factors associated with either recovery or non-improvement. It has been suggested that the introduction of the IAPT initiative has not impacted upon the increased prescribing of anti-depressants in England (Sreeharan, Madden, Lee, Millet & Majeed, 2013; Cully et al., 2017). Sreeharan et al. (2013) conducted a longitudinal time series analysis in order to examine the impact of IAPT on antidepressant prescribing rates in England, and concluded that rates increased by 10% between 2008 and 2011, and that the implementation of IAPT services had no significant effect on this. Similarly, Spence et al. (2014) reported a 165% increase in the prescribing of ADM in England between 1998 and 2012, and moreover reported that access to IAPT services was not significantly associated with the scope or increase of prescribing. It may argued however, that

increasing the number of distressed individuals being treated is helpful regardless of the method, given the reduced burden of mental illness.

The benefits of using routine outcome monitoring have been discussed in relation to the current study and indeed in relation to their importance within the IAPT initiative. Scott (2018) however, has suggested that reliance on subjective outcome measures means IAPT can provide little justification for consistent and substantial investment. Scott (2018) independently assessed 90 IAPT service users treated either before or after a personal injury claim including falls and randomised controlled trials. Assessment involved the use of semi-structured interviews and the structured clinical diagnostic interview for DSM disorders (SCID). Findings indicated that just 9.2% of these individuals recovered from their disorder. Scott (2018) highlighted the potential issues arising from differences in outcomes from IAPT assessments and SCID interviews, and that comorbidity may be missed due to the arbitrary nature of discharge criteria. He recommended more rigorous approaches to diagnosing and adherence to a more manualised approach to psychological care.

It has been suggested that scores on routine psychometric measures may decrease due to repeatedly administering tests (Longwell & Truax, 2015), a finding also highlighted by Scott (2018). Waltman (2018) however, who heavily criticised Scott's methodology and conclusions, notes that Scott (2018) neglected to acknowledge that this study (Longwell and Truax, 2015) was in fact carried out using a non-clinical population with no evidence of replication using a clinical sample.

Binnie (2018) also suggests the recommendations outlined by Scott (2018) are flawed, arguing that alternatives to the medical model are on the whole much less

stigmatising and facilitate a more human approach to helping individuals in distress, and suggests that “as psychological therapists and researchers, we should not be promoting a psychiatric ideology.” He outlines a number of methodological flaws pertaining to the outcomes reported by Scott (2018), which significantly limit the generalisability of findings. Specifically Binnie (2018) argues that it should be acknowledged that data analysed in Scott’s (2018) study, was accessed through GPs as opposed to IAPT’s national electronic clinical data. This is important, as not all IAPT service users have used their GP as referral pathway instead opting for self-referral, and not all service users consent to the GP being informed. Furthermore due to the high volume caseload which is characteristic of most IAPT services, detailed discharge reports are not ordinarily emphasised, which could explain why only 29 participants in Scott’s (2018) outcome data had both pre and post outcome data (Binnie, 2018).

There have been further criticisms regarding the evaluative methods employed by IAPT services. Timimi (2018) has proposed that services are not effective or efficient, emphasising that IAPT evaluation reports do not consider comparisons with the clinical outcomes and costs of non-IAPT services, nor do they have a comparison group. Consequently he suggests, it is not possible to determine how many individuals may have improved or recovered anyway. Furthermore IAPT data does not detail outcomes for those who declined access or for those who discontinue treatment after one session. He was also critical of the strict adherence to NICE guidelines claiming that within mental healthcare they “are based on the fantasy that expertise in technique is fundamental to improving outcomes”

Previous research has suggested that ‘common factors’ such as therapeutic rapport which are features of all talking therapies, are significantly more important than

therapeutic techniques in influencing outcomes (Wampold & Imel, 2015). Bracken et al. (2012) suggest that services and treatment outcomes are not improved by focusing on diagnosis driven models, but rather may improve by focusing on the development of purposeful relationships with service users including shared decision making. Duncan, Miller and Sparks, (2011), have suggested that flexible treatment models consistently informed by service user feedback have been shown to improve treatment outcomes, and moreover reduce the possibility of longer-term use. It should be noted however that within IAPT step 2 services, PWPs are assessed and required to be competent in both common and therapy specific factors (Richards & Whyte, 2011), and moreover a collaborative therapeutic style and shared decision making is a key feature of LICBT.

The perspectives of service users themselves are fundamental to this debate surrounding diagnosis driven models of care. Some individuals report feeling relief and of achieving some level of validation in terms of their distress, as well as increased connectedness, optimism and empowerment (Boyle &Johnstone, 2014; Leamy et al., 2011), whereas others suggest a statement of diagnosis diminished their sense of identity, invalidated their distress and increased feelings of fear shame and despair (Boyle & Johnstone, 2014). Johnstone and Boyle, (2018), proposed the Power-Threat-Meaning framework, the long-term objective of which is to discourage diagnostic thinking. It essentially summarises evidence about the function of powers, threats which result from misuse of power, how people have learned to respond to threat, and how information from broader society can intensify feelings of shame, guilt, fear and isolation. It is reasonable to suggest that the potentially harmful impact of recent austerity may be obscured by diagnostic thinking, intensifying the problems of individuals already overwhelmed by burdensome circumstances. It is

essential however, to protect the rights of people who require diagnoses in order to access certain services and benefits, and furthermore the rights of all people to describe their experiences in the way that they prefer.

Whilst it is important to consider the criticisms of and challenges for the IAPT initiative, it is equally important to reiterate and acknowledge that the model has transformed the treatment of common mental health difficulties, primarily depression and anxiety disorders. It is estimated that approximately 950000 individuals access IAPT services annually with 50% of these achieving reliable recovery and two thirds achieving reliable clinical improvement (NCCMH, 2018). It is imperative that services in NI should seek a way to emulate this and address the gap in service provision for mild and moderate difficulties, as it may be argued that those in need of this care, continue to be failed (DHSSPS, 2016; HSC 2014; Blane et al., 2014; Betts & Thompson, 2017 ; McDevitt-Petrovic, 2018).

8.3 Limitations

It is important to interpret the outcomes determined from the investigations of reliable symptom change in the appropriate context. The current evaluation is not of an official IAPT service, and trainee PWP's were not working with a particularly high volume caseload and the sample data was significantly smaller than national IAPT records. The proportion of patients who completed follow-up data was also very small, although as discussed, the promising outcomes indicate that a larger longitudinal investigation would be viable. Moreover, national IAPT data included individuals who may have received both low and high intensity interventions over the course of their treatment, and the current study considered low intensity interventions exclusively. However, the favourable rates of reliable improvement

and recovery should be recognised. The absence of a control group and lack of random allocation is an acknowledged limitation of the quantitative evaluation of the NI PWP service, although a randomised controlled trial is feasible for future research.

When the predictors of treatment response are considered, it is important to acknowledge that the possibility of bias cannot be discounted. This relates particularly to potential self-report bias and to potential confirmatory bias, given that this pre-treatment information was interpreted subjectively by practitioners. Similarly with respect to the qualitative evaluation, there is a potential for bias associated with self-reporting data and socially acceptable narratives, however reassurances of anonymity were provided verbally and in writing. There was also a relatively small and selective sample involved in the qualitative evaluation, potentially impacting the generalisability of findings, however this decision was made based on recommendations that such samples enhance the depth of data (Smith, 2013).

Although a high prevalence of non-cardiac chest pain was determined in relation to the data analysed in Chapter 6, it is important to reiterate that the data analysed pertained only to single counts of emergency department presentations and their corresponding diagnoses/discharge status. It was therefore not possible to determine the rates of repeat attendance among these, although this has been declared as a future research recommendation. Furthermore, the formats for recording information on the ED database which was analysed was not standardised, however, a thorough systematic review of entries was carried out in addition to inter-reliability measures. There are further issues with the generalisability of results given that the focus was on a single ED department, however, this urban hospital covers a significantly large

geographical area. Finally it is must be acknowledged that the studies screened for inclusion in the final synthesis of the systematic review were screened by only one author (with the exception of the risk of bias assessments), therefore the possibility of a study being missed was increased.

8.4 Clinical practice recommendations

The following recommendations are proposed for NI

- The development of evidence – based clinical guidelines, similar to NICE, as also recommended by Clark (2016), for anyone endeavouring to implement services similar to IAPT.
- The sessional collection of routine outcome measures to facilitate more robust monitoring, and to support funding and the feasibility of LICBT services.
- The facilitation of a self-referral option for clients seeking a PWP service. This has been shown to improve access to treatment for those frequently underrepresented in GP referrals (Gyani et al., 2013; Lovell et al., 2014).
- In general the pathways to care for individuals with common mental health difficulties and medically unexplained symptoms in NI remains unclear, and clearer referral and treatment pathways must be established.
- Service provisions should be adapted to meet needs at a local level; e.g. in areas of high deprivation. Individual IAPT services are refined in accordance with the requirements of their respective locations and their populations (Clark et al., 2009; Glover et al., 2010; Richards & Borglin, 2011; Sharp et al., 2014).

- A comprehensive and evidence based inclusion/exclusion criteria should be developed in order to enhance the efficiency of referral/triage decisions; effective decision making at the point of referral is essential in order to facilitate a properly functioning stepped care framework for treatment provision. A review of care should be considered for those who have not demonstrated improvement after 6 sessions.
- The possibility of booster sessions as part of relapse prevention plans should be considered.
- A wider systems approach should be developed in order to improve collaboration and communication and the sharing of expertise, with the aim of minimising the likelihood and impact of interprofessional difficulties.
- As highlighted earlier, trainee PWPs operating within a social prescribing project have been described as very effective. Given the link with psychological wellbeing, and the fact that LICBT lends itself to the concept of social prescribing, consideration should be given to embedding PWPs within social prescribing programmes.
- Promote awareness and acceptability of guided self-help/LICBT/PWPs among potential service providers and potential service users. As suggested by the qualitative outcomes reported and by recent recommendations resulting from the Bamford evaluation, the involvement of the community and voluntary sector should be increased.
- It is essential to develop and adhere to realistic waiting times for Step 2. Overly long waiting times are associated with delayed access to treatment and subsequently poorer treatment outcomes (Dell’Osso, Glick, Baldwin & Altmura, 2013). This was also alluded to by a number of the service

providers interviewed in Chapter 5, several of whom discussed a deterioration in clients waiting too long to access care, simultaneously increasing the likelihood that they would be unsuitable for LICBT.

- More work must be done to reduce the impact of stigma on help seeking and attendance of appointments for mental health difficulties in NI.
- There must be adequate training for staff in emergency departments in relation to medically unexplained physical symptoms associated with psychological distress, and moreover in relation to appropriate onward referral for this patient population.

8.5 Future research recommendations

- As discussed, recent research has reported more favourable clinical outcomes for patients treated by qualified as opposed to trainee PWPs (Branson et al., 2018). Research evaluating the outcomes of qualified PWPs working in NI is feasible.
- Further research investigating the associations between therapist experience, competence and clinical outcomes is recommend particularly in relation to low intensity treatments (Branson et al., 2018).
- An evaluation of the effectiveness of a self-referral service
- Investigation of service level variables in relation to predicting treatment outcome.
- Further exploration of the individual usual level variables predictive of treatment response is also warranted, in particular the effects of psychotropic medications on treatment response.

- A cost-benefit analysis in relation to a fully established and accessible PWP service.
- As indicated in the clinical practice recommendations above, the potential benefits of using PWPs as part of a social prescribing programme should be investigated.
- Exploring the perspectives of service users (initial promising outcomes have been reported by service providers).
- Investigate the degree of repeat attendance in NCCP and moreover the prevalence and types of anxiety among this patient population.
- Future research may take the form of a randomised controlled trial facilitating the piloting of a LICBT intervention. The first element would provide patients with MUS with some type of psychoeducational material regarding the nature of anxiety symptoms. The second element would involve setting up a referral pathway from emergency department staff to the GP. The GP would subsequently refer the patient to the psychological therapies hub from which onward referral to the appropriate service (PWP for mild to moderate level), could be made.

8.6 Conclusions

8.6.1 Thesis conclusions

Despite criticisms and ongoing challenges, the IAPT initiative within which LICBT is a key feature has transformed the treatment of common mental health difficulties in England and overall is regarded as a success (Clark, 2016; Freeston, 2016).

Specifically there has been a vast expansion of services, significant increases in self-referrals, improved throughputs and waiting times, workforce development, more training and supervision training opportunities, improved data retention and

favourable public opinion (Clark, 2016; Freeston, 2016). Clark (2016) and Freeston (2016) have however acknowledged the implications of a burden which sometimes accompanies success. Specifically it has been highlighted that many more individuals are seeking help for access to mental health care and moreover, the proportion of people with complex and comorbid difficulties has increased, such as MUS, ASD, personality disorder and intellectual and learning disability alongside depression and anxiety. Consequently it has been noted that work at Step 2 PWP is becoming increasingly demanding.

David Clark (2016) who is the National Clinical advisor to the English IAPT initiative outlined advice for those keen to develop stepped care frameworks of care modelled on the IAPT, specifically:

- Development of evidence based clinical guidelines similar to those produced by NICE.
- Collection of routine outcome measures data in order to support funding
- Obtaining support from service users and providers
- Meeting targets agreed with politicians
- Creating an ‘innovation environment whereby recovery focused practitioners would provide effective and evidence based psychological therapies.

As discussed, collaboration and shared expertise has been integral to the implementation of and subsequent successes of the English IAPT initiative.

In relation to NI, it is important to be mindful, that research has highlighted a lack of clear service delivery models, poor leadership and insufficient government support which is strongly linked with poor and unequal access to timely and appropriate treatment (Mc Manus et al., 2009; Seward & Clark, 2010).

The prevalence of mental health problems in NI is 25% higher than in England (DHSSPS, 2014), the extent of need is very clear. It is reasonable to assume that at least some of these individuals could benefit from early intervention at Step 2, and furthermore as the research evidence presented in the current thesis suggests, that an established and adequately staffed PWP service in NI may contribute to reducing the burden of mental health difficulties as the IAPT initiative has. The current study is the only study in NI to attempt to evaluate a proposed new service model for the region. Existing services attempting to provide a Step 2 level of care do not exist, nor has there been any attempt to determine evidence of effectiveness. The current findings are clinically and economically significant, and policy makers may make use of them during essential decision making around service development going forward.

The recent evaluation of Bamford Action plans (DH, 2016) highlighted a need to further promote psychological therapies and to increase involvement at the community and voluntary level (DH, 2016; Betts & Thompson, 2017). It may be concluded that the research evidence presented in the current thesis supports that PWPs have addressed this need.

This project also contains presents the first UK based study to employ GMM methods to determine predictors of outcomes following LICBT delivered by PWPs. The predictors identified, namely unemployment, risk of suicide, neglect of self or others, using medication, receiving previous or concurrent treatments, a longer duration of difficulties, and comorbidities, should be considered in relation to LICBT suitability criteria.

The service has been recognised as clinically effective by service providers who reported receiving similar favourable feedback from their service users, and moreover they unanimously acknowledge that PWPs fill a current gap in service provision i.e. for those with mild to moderate level depression and anxiety. It is clear however from the perspective of PWP service providers in NI, that more must be done to improve access to this and other services. Specifically we must work to increase awareness of PWPs in order to subsequently increase availability and utilization ; “for PWPs to work, time is of the essence.”

Collaboration must also be improved to reduce interprofessional difficulties, and it may be useful to begin by promoting awareness of the PWP service among more service providers. It should be restated however, that the level of frustration regarding the absence of a functioning government executive in NI is high, and that concrete decisions about future healthcare service developments cannot actually be made while this persists.

Nevertheless, the potential effectiveness of a fully implemented and sufficiently staffed PWP service is clear (McDevitt-Petrovic et al., 2018). Commissioners and service providers must understand the prevalence of difficulties and unique needs of the population in order to facilitate better access to services. The significant need identified in relation to NCCP must also be accepted (McDevitt-Petrovic et al., 2017). Further work is required to understand the links between physical and mental health and to facilitate access to timely and appropriate care for this patient population in keeping with how IAPT services in England are developing.

8.6.3 A new service model for NI

PWPs are well established, and regarded as an extremely effective workforce within the IAPT initiative in England. Given the current gap in service provision at Step 2 in NI, the promising outcomes reported here, suggest that PWPs are effective (at least clinically), in NI also. It must be acknowledged however, that establishing a fully staffed PWP service within a functioning and cost beneficial stepped care model in NI, may require a move towards the more high volume approach endorsed by the English IAPT initiative. As highlighted previously, this approach has been criticised, specifically for being ‘industrialised’ and potentially dismissive of patient narrative; moreover there are consistent issues around retention of the workforce due to apparent ‘burnout’ and the desire to progress as practitioner (NCCMH, 2018). However, while the PWP role is highly structured, it nonetheless requires a commitment to collaborative care and is very patient – centred, with a focus on shared decision making and self-management which is ultimately empowering for clients, and can reduce the risk of relapse. It can be reasonably suggested that the benefits far outweigh the potential pitfalls; it may be the case that the success of the workforce in NI will be heavily dependent on how the service is implemented, structured and supported, and modified according to local area need.

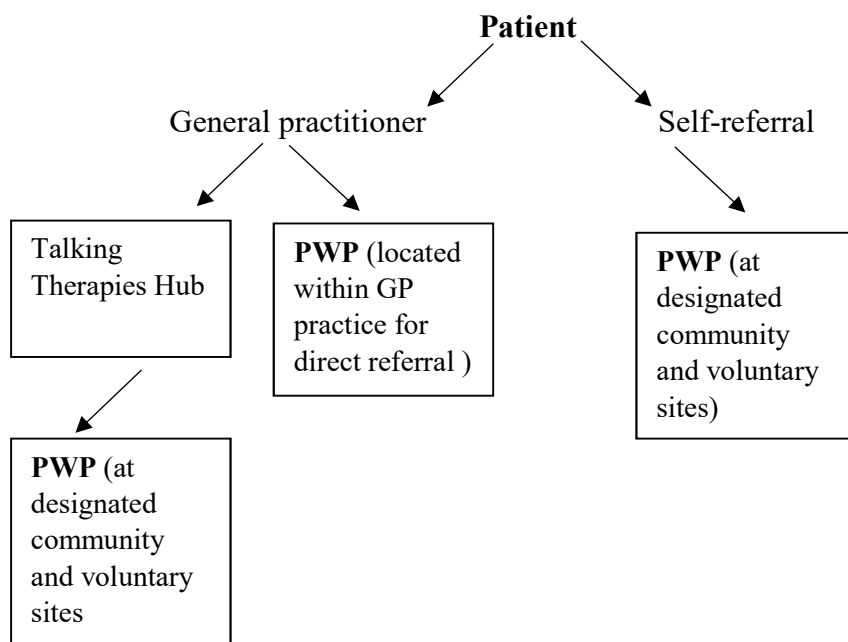


Figure 8.1 Proposed referral pathways from patient to PWP

Figure 8.1 illustrates a clear and more flexible pathway of referral, beginning with the potential patient seeking help, and leading to the point of accessing a PWP through using either a self-referral option or a referral via a GP. Where a patient is determined to be unsuitable for LICBT at the point of referral or assessment, they may be immediately stepped up to higher intensity/specialist care. Step up can also be agreed as a course of action with the agreement of PWPs, patients and clinical supervisors in cases where a patient has failed to improve or adequately responds to LICBT. Patients should have a choice of face to face, telephone, group or digital therapy. PWPs should furthermore be able to link with social prescribers, or indeed socially prescribe themselves, linking with third party organisations in order to support behavioural activation.

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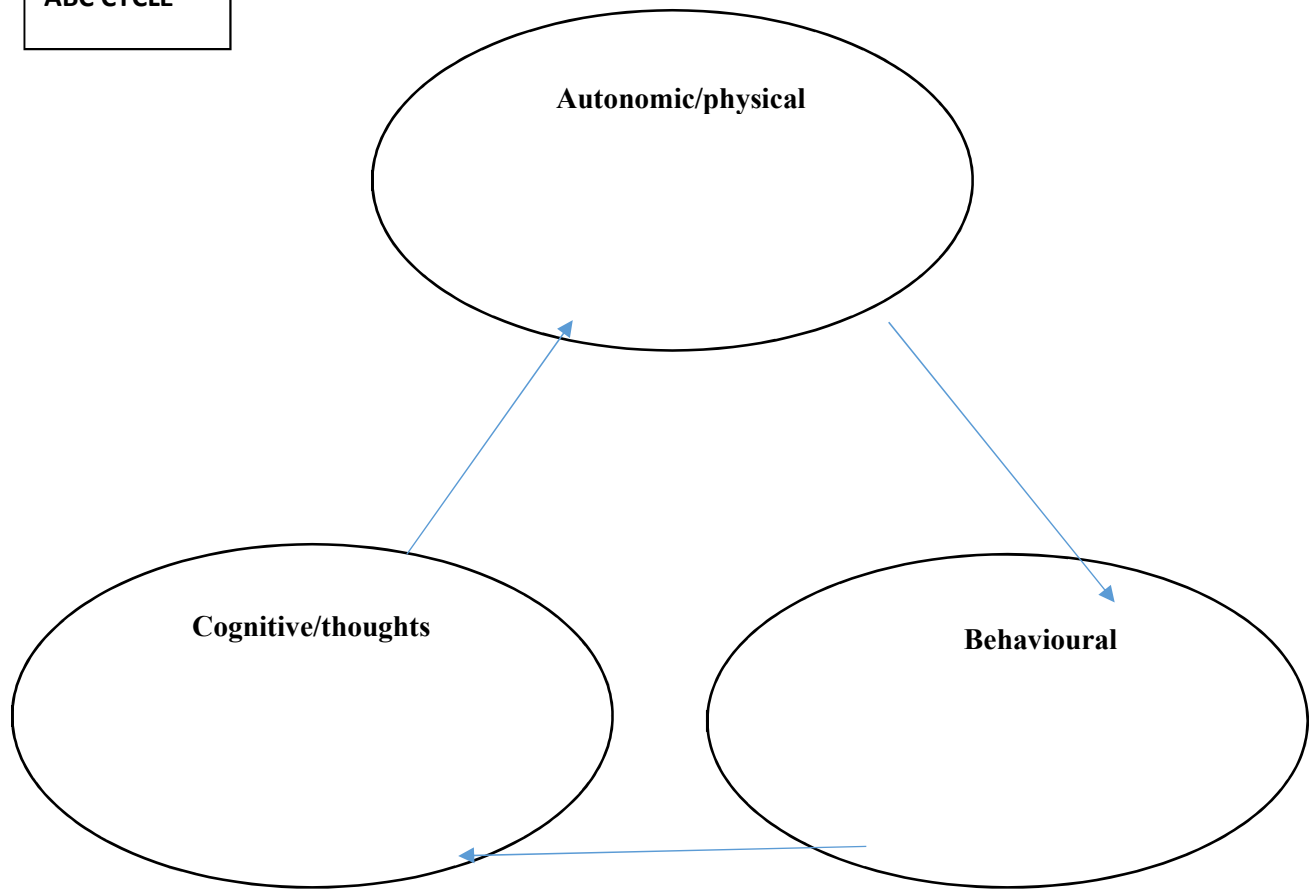
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Appendix A

CLINICAL ASSESSMENT INTERVIEW SCHEDULE

Name of PWP	
Name of client	
Client contact info	
Client age	
Client gender	
Referral method (GP/ self/ Primary Care Team/Hub/other).	
Employment Status	
Marital Status	

<u>Introductions</u> : role of PWP, confidentiality, purpose and timescale of interview
<u>'4 Ws'</u>
What is the problem?
Where does the problem occur?
With whom is the problem better or worse?
When does the problem happen?
<u>Triggers</u>
Specific examples of situations/other stimuli which trigger the problem in the here and now
Past examples of triggers

ABC CYCLE

Emotional/feelings

<u>IMPACT (CONSEQUENCES) OF PROBLEM</u>
Work
Home management
Leisure
Family life
Relationships
Other/Overall

ASSESSMENT OF RISK	
Current risk	Previous risk
Thoughts of life not worth living	Thoughts of life not worth living
Thoughts of harming self	Thoughts of harming self
Intent (suicidal thoughts)	Intent (suicidal thoughts)
Plans (specific action plans)	Plans (specific action plans)
Actions/access to means	Actions/access to means
Risk to others (thoughts/plans/actions)	Risk to others (thoughts/plans/actions)
Neglect of self or others	Neglect of self or others
Prevention (social network/services)	

Routine Outcome measures <u>IAPT minimum data set including at least the PHQ-9 and GAD-7</u>
PHQ-9 initial session score:
GAD-7 initial session score:
Other psychometrics, e.g. WSAS:

OTHER IMPORTANT INFORMATION TO GATHER
Onset and maintenance
Why does the patient want help now?
Patient expectations and goals
Past episodes and treatments
Alcohol use (please indicate frequency, amount, type, when, where and with whom).
Drug use (please indicate frequency, amount, type, when, where and with whom).
Medication (please name medication if applicable, and include details regarding attitude towards medication and concordance) :
Other treatments being provided
Anything else relevant not yet covered

<u>RESEARCH PARTICIPATION</u>	
Explain purpose of service evaluation/ give information letter. Client can take information sheet away to read, and return in subsequent session if preferred.	
<u>Client response:</u> Consent obtained	Consent withheld
<input type="checkbox"/>	<input type="checkbox"/>

<u>OUTCOME OF INITIAL ASSESSMENT</u>
Presenting problem as identified by PWP e.g depression, general anxiety, specific phobia etc...
Details of next agreed contact e.g. arranged, declined, stepped up etc...

Appendix B

Participant Invitation Letter

School of Psychology, Ulster University, Magee Campus, Northland Road,
Londonderry/Derry, BT48 7JL

Re: Research Project title: 'Pilot evaluation of low-intensity CBT in Northern Ireland'.

Dear Sir/Madam,

I am writing to invite you to participate in a research study, which relates to the therapy that you are currently receiving from the Psychological Wellbeing Practitioner (PWP) (in training), who has been working in the local service that you are attending. You may recall that your PWP therapist has explained the importance of monitoring your therapy progress by using questionnaires called the GAD7 which monitors anxiety levels, and PHQ9 which monitors depression levels. As part of routine practice, your PWP has asked you to complete these questionnaires at each therapy session to see how you are progressing and/or help him/her to adapt the therapy to suit your needs. These questionnaires can also indicate whether this type of therapy (low-intensity CBT) is helpful for other people, and therefore this data could be used for research purposes, but only if the clients consent to allowing us to pool this data together for further research analysis.

Hence, the details below aim to outline the rationale for the current study in more specific detail than was verbally discussed with you, seeking your consent to participate in a regional study. This means seeking your permission to use this anonymised existing data /information for research purposes, and to contact you in the future (approx. 4 months after you are discharged from the service) to follow up on your progress.

To make things easier, I have attached a question and answer information sheet, which outlines what this will involve. We hope you have time to read this as it should help you make an informed decision about participating in the study or not. After this, your therapist (or another professional therapist/supervisor working in the service) will ask you to sign the attached consent form to confirm this agreement. Please be aware that you do not have to participate in this study and if you want to decline, there will be absolutely no consequences to your therapy whatsoever.

Thanking you most sincerely for taking the time to read this letter,

Kind regards,



Dr Karen Kirby, PhD, Chief Investigator, Lecturer of Psychology, Ulster University.

Email: k.kirby@ulster.ac.uk

Tel contact: 028 71 67510



Participant Information Q&A Sheet

Why do we need to evaluate the service you have received?

The therapist who is currently working with you is called a 'Psychological Wellbeing Practitioner (PWP)' (in training) and the therapy they are using is called low-intensity Cognitive Behaviour Therapy for mild to moderate mental health problems. This is a new practitioner role and type of therapy being conducted across Northern Ireland since 2015. We now need to conduct research to see whether or not this therapy is useful and effective

Is there any risk to me if I get involved in this study?

No, there is no risk to people participating in this study. I am asking your permission to allow some of your personal but anonymised data that you have already provided, to be used in this research study. By personal information, I mean basic social and demographic information, as well as a photocopy of the questionnaires that your therapist filled out each week, as part of the therapy to check your progress. Your name will be removed from all documents and therefore your identity is protected.

What do I have to do exactly?

You can participate in this study by signing the attached consent form; by doing this you are giving permission that some of the data already collected during your therapy sessions can be used in this research study. Information relating to your age, gender and social circumstances, whether you are on medication, the main type of problem you presented with, and any other relevant health information, will be used. However, information relating to your name, DOB or address is **not needed** to evaluate the usefulness of the type of therapy you received.

You may also remember that your therapist used two questionnaires in each of your therapy sessions: one to measure depression (the 'PHQ9'), and the other to measure worry and anxiety levels (the 'GAD7'). These questionnaires help the therapist to gauge whether the therapy is working as planned or whether a change in the course of the therapy is needed. I would like permission to photocopy the session by session questionnaires that your therapist completed as part of your therapy. As stated earlier, I just want to copy and collate your anonymised data and to add this to a large database of information from all people in Northern Ireland who also received this type of therapy during 2015/2016. To be clear, when the questionnaires are photocopied, please be assured that your name will be removed to protect your identity.

Finally, in order to assess whether the therapy has been helpful to you in the long-term, I would like to contact you again approximately 4 months after your therapy has ended. This will involve a phone call at a time and date that suits you. During this phone call, the PWP (in training) will ask you to complete the two questionnaires (the PHQ9 and the GAD7) one last time. Completing these questionnaires again will provide information as to how you are doing in relation to your mental health difficulties in the longer-term after your

therapy has finished. To be clear, if you consent to this now, that means you will be contacted in 4 months' time to complete these same questionnaires over the phone, and this should take less than 15 minutes. If you would prefer, it can be arranged that the two short questionnaires can be posted to you and you can complete in your own time, and then return them in a self-stamped addressed envelope.

If you feel you need further help when you are contacted 4 months after your therapy has ended, an appropriate referral can be made for you at that time.

What will happen now, and how do I provide consent?

Approximately one-to-two weeks after you have received this information pack from your PWP therapist (either in person or in the post), your therapist (or another professional therapist working within the service you are attending), will ask you if you agree to participate. You are under no pressure to participate, but if you are happy to participate in this research study, the therapist will seek your written consent and ask if you want to sign a consent form (see attached).

What if I do not want to participate in this study?

It is very important that I emphasise that you do not have to agree to have your anonymised data included in this research study. If you do not wish to take part, this will not have any impact on your therapy or mental health care needs in the future. Also, if you do agree to take part in the research study but you change your mind at a later time, you have the right to withdraw from the study at any time. Even if you consent to this now, but in 4 months' time, you change your mind and opt out, this is fine too. When we call, we will remind you about the study and check in with you that you are still happy to go ahead with completing the two short questionnaires 4 months following the end of your therapy.

Our main hope is that the therapy you are receiving is making a positive difference to your life, and that you will overall achieve a positive outcome when it is completed.

Kind regards,

Dr Karen Kirby, PhD,

Chief Investigator, Lecturer of Psychology.

Email: k.kirby@ulster.ac.uk

Tel contact: 028 71 67510

School of Psychology, Ulster University, Magee Campus, Northland Road,
Londonderry/Derry, BT48 7JL

This study is also being assisted by Orla McDevitt-Petrovic, PhD student at Ulster University.

Appendix C



Participant Consent Form

Project title: 'Pilot evaluation of low-intensity CBT in Northern Ireland'

1. I confirm that I have received the information sheet for the above study and I have read and understood it and have asked and received answers to my questions raised.

Please tick: ☐

2. I am aware that my participation is voluntary and that I can withdraw from this study at any time, for any reason, without adverse consequences.

Please tick: ☐

3. I understand that all information and data collected will be kept confidential and stored securely and that confidentially.

Please tick: ☐

4. I understand that all efforts will be made to ensure that I cannot be identified personally as a participant in this study (except as might be required by law).

Please tick: ☐

5. I agree to take part in this study.

Please tick: ☐

6. If for any reason I become concerned or need more information about this study, I know that I can speak to my therapist or contact the chief investigators below.

Please tick: ☐

Participants name (Printed): _____

Participants Signature: _____

Please note that your signature here will be kept separate from the anonymised data, so that your identity is protected.

Signature of PWP issuing the consent form: _____

Date: _____

Chief investigator: Dr Karen Kirby
675109

Email: k.kirby@ulster.ac.uk.

Tel: 028 71

Appendix D

PHQ-9 Depression

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Please circle your answer)

	Not all	at Several days	More than half the days	Nearly every day		
1. Little interest or pleasure in doing things.....	0	1	2	3		
2. Feeling down, depressed, or hopeless.....	0	1	2	3		
3. Trouble falling or staying asleep, or sleeping too much.....	0	1	2	3		
4. Feeling tired or having little energy.....	0	1	2	3		
5. Poor appetite or overeating.....	0	1	2	3		
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.....	0	1	2	3		
7. Trouble concentrating on things, such as reading the newspaper or watching television.....	0	1	2	3		
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.....	0	1	2	3		
9. Thoughts that you would be better off dead or of hurting yourself in some way.....	0	1	2	3		
Column totals	___	+	___	+	___	+
	= Total Score					

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring notes.

- **PHQ-9 Depression Severity**

Scores represent: **1-4 = Minimal Depression**

5 - 9 = Mild Depression

10 - 14 = Moderately Depression

15 - 19 = Moderately Severe Depression

20 - 27 = Severe depression

Appendix E

GAD-7 Anxiety

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems? (Use “✓” to indicate your answer”	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Column totals: + + +

= **Total Score**

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

**Not difficult
at all**
☐

**Somewhat
difficult**
☐

**Very
difficult**
☐

**Extremely
difficult**
☐

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams,

Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring Notes

- **GAD-7 Anxiety Severity.**
-

This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of “not at all,” “several days,” “more than half the days,” and “nearly every day,” respectively. GAD-7 total score for the seven items ranges from 0 to 21.

Scores represent: **0-5 mild**

6-10 moderate

11-15 moderately severe anxiety

16-21 severe anxiety.



Appendix F

Service providers (information and consent)

School of Psychology, Ulster University, Magee Campus, Northland Road, Londonderry/Derry, BT48 7JL

Dear PWP Placement Provider,

Throughout this year, you have been supporting our MSc in Applied Psychology (Mental Health and Psychological Therapies) course by facilitating our students to undertake a placement as a Psychological Wellbeing Practitioner (PWP) trainee in your organisation. As a course team, we feel this has been a fantastic opportunity for our students and we hope that you have also valued the experience.

At the University, we are very interested in evaluating the effectiveness of the therapy provided by our PWP trainees to clients attending your service who have experienced mild-moderate mental health problems.

This research project is titled: **Pilot evaluation of low-intensity cognitive behavioural therapy (CBT) for mild-moderate mental health problems in primary care: a Northern Ireland based study.**

In order to do this, we need to apply for ethical approval to contact all clients who received the course of low-intensity CBT from our PWP trainees for permission to use their anonymised personal and clinical data for this research study. For the purposes of the ethical approval application, we need you, as the host site of the placement to support the study, but also to give the University permission to contact all clients (via the PWP trainees) seeking the clients own consent to participate in the study for access to their anonymised data and for 4 month follow up reviews.

If you give permission, this will mean that the attached information letter and consent form will be posted to each client who received therapy from our PWP trainees during their placement at your organisation. I have attached a copy of this document for your perusal. If you consent to your organisation taking part, please sign and return the **attached organisation consent form**, either via post or via email using the contact details below.

We hope that you will consider this request.

It is very important that we have research evidence to demonstrate the effectiveness of this low-intensity CBT method, in reducing/preventing adult mental health problems in Northern Ireland.

Thank you for your time. If you have any queries, please do not hesitate to contact me.

Kind regards

Dr Karen Kirby
(Chief Investigator)

Consent statements

We confirm that we have received the information for the above study and we have read and understood it and have asked and received answers to my questions raised.

Please tick:

We understand that all information and data collected will be kept confidential and stored securely at Ulster University.

Please tick:

We understand that all efforts will be made to ensure that our clients cannot be identified personally as a participant in this study (except as might be required by law).

Please tick:

As an organisation/ placement provider, we agree to take part in this study.

Please tick:

Name of host Organisation/Placement provider for trainee PWP's:

Name of lead contact/managers/directors

Signature _____ Date _____

Kind regards

Dr Karen Kirby, PhD
Lecturer of Psychology (Chief investigator of the research project)
Email: k.kirby@ulster.ac.uk Tel contact: 028 71 675109

Appendix G
IRAS APPROVAL



Health Research Authority
London - Camden & Kings Cross Research Ethics Committee

Room 001
Jarrow Business Centre
Rolling Mill Road
Jarrow
Tyne & Wear
NE32 3DT

Telep

hone: 0207 104 8086 17 February 2016

Dr Karen Kirby
School of Psychology
Ulster University
Northland Road, Londonderry
BT487JL

Dear Dr Kirby

Study title:	Pilot evaluation of low-intensity cognitive behavioural therapy (CBT) for mild-moderate mental health problems in primary care: a Northern Ireland based study
REC reference:	16/LO/0343
Protocol number:	16/0016
IRAS project ID:	181559

The Proportionate Review Sub-committee of the London - Camden & Kings Cross Research Ethics Committee reviewed the above application in correspondence.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager Miss Christie Ord, nrescommittee.london-camdenandkingscross@nhs.net. Under very limited

circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Ethical opinion – Favourable Opinion

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA Approval (England)/ NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see “Conditions of the favourable opinion”).

Summary of discussion at the meeting

The PR Sub-Committee raised the following queries in email correspondence with you between the 15th and 16th February 2016.

Informed consent process and the adequacy and completeness of participant information

The PR Sub-Committee requested an amendment to the Participant Information Sheet to state that a participant’s GP would be notified of their involvement should there be any concerns about their health or wellbeing at the 4 month follow up, and for the addition of a row on the consent form for the participant to acknowledge that they are aware the researcher will do this.

You provided the amended documents.

The PR Sub-Committee accepted this response.

Approved documents

The documents reviewed and approved were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering letter on headed paper [Cover Letter]	1	08 February 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Ulster Univeristy Sponsor Indemnity letters]	1	
GP/consultant information sheets or letters [Letter to PWP placement provider]	Version 1	09 February 2016
Letter from sponsor	1	08 February 2016
Letters of invitation to participant [Participant invitation letter within this]	Version 1	09 February 2016
Letters of invitation to participant [Revised Invitation with consent form]	Version 2	16 February 2016
Other [Host Site Consent form Belfast Trust]	1	08 February 2016
Other [Host Site Consent Western Trust]	1	08 February 2016
Participant information sheet (PIS) [Revised PIS and consent form]	Version 2	16 February 2016
REC Application Form [REC_Form_08022016]		08 February 2016
Research protocol or project proposal [Research Proposal Project ID 181559]	Version1	09 February 2016
Summary CV for Chief Investigator (CI)	1	08 February 2016
Summary CV for student		
Summary CV for supervisor (student research) [CV of PhD student]	1	08 February 2016
Validated questionnaire [Validated PHQ9 and GAD7]	1	08 February 2016

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

16/LO/0343

Please quote this number on all correspondence

Yours sincerely

pp 

Ms Heidi Chandler Vice Chair

Email: nrescommittee.london-camdenandkingscross@nhs.net

Enclosures: List of names and professions of members who took part in the review

"After ethical review – guidance for researchers"

Copy to: Mr Nick Curry, Ulster University

*Mrs Bridgeen Rutherford, Western Trust R & D office,
Western Health and Social Care Trust*

London - Camden & Kings Cross Research

Ethics Committee

Attendance at PRS Sub-Committee of the REC meeting in correspondence

Committee Members:


<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Ms Heidi Chandler (Chair)	Research Co-ordinator	Yes	
Dr Andy Petros	Consultant Paediatric Intensivist	Yes	
Mrs Beverley Taylor	Lawyer	Yes	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Miss Christie Ord	REC Manager

Appendix H

ORECNI documents

 **Ulster University**

Ulster University
 2000 Road
 Newtownabbey
 County Antrim
 BT37 0YB
 Northern Ireland
 T: +44 (0)28 9036 6522/6519/6629
 F: +44 (0)28 9036 4479
 ulster.ac.uk

ULSTER UNIVERSITY **RESEARCH GOVERNANCE**

Research on human participants being conducted by staff and/or students of the University

Please find attached a letter from the University noting that your application to undertake research involving human participants has gained a favourable ethical opinion from an HSC/NHS ethics committee and/or HSC Trust as appropriate.

Policies related to research in the HSC/NHS require the Research Governance section to:

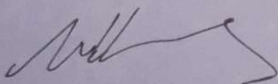
- Seek confirmation that arrangements are in place for the research to begin, including arrangements to manage the study
- Ensure that the research protocol, the investigators and the environment are appropriate
- Confirm that ethical approval has been obtained before a study begins, where required
- Ensure that good practice arrangements are maintained for the duration of the study in relation to the conduct of the study, monitoring and reporting (including the immediate reporting of adverse events)

The requirements upon the investigators are to:

- conduct the study in line with the approved protocol
- retain and maintain records, including hard copies of signed consent forms, appropriately
- provide reports as required during and at the end of the study
- report any adverse events
- seek prior approval for amendments to the protocol

In addition to complying with the University's requirements, you must also familiarise yourself with the requirements of any other organisations involved in the research as collaborators, hosts or funders.

Please do not hesitate to contact me should you require any further information.



Nick Curry
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 Research Governance
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Our Ref: NC:GOV

17 February 2016

Dr K Kirby
 School of Psychology
 Ulster University
 Magee Campus

Dear Dr Kirby

Research Governance Reference Number: 16/0016

ORECNI Reference Number: 16/LO/0343

Study Title: Pilot evaluation of low-intensity cognitive behavioural therapy (CBT) for mild-moderate mental health problems in primary care: a Northern Ireland based study

The Research Governance section has been advised that the above application has been given a favourable ethical opinion by an HSC/NHS ethics committee. Once you have gained permission from the Trust(s) involved, the research can proceed.

Please note the additional documentation relating to research governance and indemnity matters, including the requirements placed upon you as Chief Investigator.

1. Please complete and return the Chief Investigator Statement of Compliance prior to commencing the study and keep a copy for your file.
2. Please retain all other documents.

Further details of the University's policy along with guidance notes, procedures, terms of reference and forms are available at the following web address:

<http://research.ulster.ac.uk/office/rofficeeg.html>

If you need any further information or clarification of any points, please do not hesitate to contact me.

Yours sincerely

Nick Curry
 Senior Administrative Officer
 Research Governance
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ULSTER UNIVERSITY

RESEARCH GOVERNANCE

Project Reference Number: 16/0016

Project Title: Pilot evaluation of low-intensity cognitive behavioural therapy (CBT) for mild-moderate mental health problems in primary care: a Northern Ireland based study

Statement on indemnity for staff and students conducting research on human participants

The University is indemnified, through its insurance policies (and subject to the terms and conditions of these policies), for its staff and students engaged in the pursuit of research involving human participants where the research is being conducted for and on behalf, and with the prior knowledge and consent of, the University.

However, the University is not indemnified through its insurance for non-negligent harm. Legal liability does not arise where a person suffers harm but no-one has acted negligently. The University cannot offer advance indemnities or, generally, insure against non-negligent harm, although such indemnity can be applied for in specific cases and where it is considered to be an essential element of the study.

Participants in research studies (research subjects) should be made aware in the information provided to them of the University's position.

This statement is only valid if it is on headed paper, is signed and bears the Research Governance stamp.

Nick Curry
 Senior Administrative Officer
 Research Governance

DATE: 17 February 2016



Appendix I

Iras approval (amendments for qualitative study)



Health Research Authority

London - Camden & Kings Cross Research Ethics Committee

Jarrow Business Centre
Rolling Mill Road
Jarrow
NE32 3DT

Tel: 02071048083

20 February 2018

Mrs Orla Marie Mc Devitt-Petrovic

School of Psychology

Ulster University

Northland Road

BT48 0HE

<i>Document</i>	<i>Version</i>	<i>Date</i>
Interview schedules or topic guides for participants [Interview schedule - service users - clean]	1	19 September 2017
Interview schedules or topic guides for participants [Interview schedule - service providers - clean]	1	19 September 2017

Notice of Substantial Amendment (non-CTIMP) [Substantial amendment form]	SA1	19 September 2017
Participant information sheet (PIS) [Participant information sheet/informed consent form - service users - clean]	1	19 September 2017

Dear Mrs Mc Devitt-Petrovic

Study title: Pilot evaluation of low-intensity cognitive behavioural therapy (CBT) for mild-moderate mental health problems in primary care: a Northern Ireland based study

REC reference: 16/LO/0343

Protocol number: 16/0016

Amendment number: SA1

Amendment date: 19 September 2017

IRAS project ID: 181559

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion – Favourable Opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

sheet/informed consent form - service providers - clean]		
Participant information sheet (PIS) [Participant information sheet/informed consent form - service users - clean]	1	19 September 2017
Research protocol or project proposal [Protocol - tracked]	2	29 January 2018

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our Research Ethics Committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

16/LO/0343:	Please quote this number on all correspondence
--------------------	---

Yours sincerely

Pp



Mrs Rosie Glazebrook

Chair

E-mail: nrescommittee.london-camdenandkingscross@nhs.net

Enclosures: List of names and professions of members who took part in the review

*Copy to: Mrs Bridgeen Rutherford, Western Trust R & D office, Western Health and Social Care Trust
Mrs Orla Marie Mc Devitt-Petrovic*

London - Camden & Kings Cross Research Ethics

Committee

Attendance at Sub-Committee of the REC meeting held via correspondence

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Mrs Rosie Glazebrook (Chair)	Consumer Marketing	Yes	
Dr Jacqueline Maxmin	Retired GP	Yes	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Miss Christie Ord	REC Manager

Appendix J



Participant Information sheet

**School of Psychology, Ulster University, Magee Campus, Northland Road,
Londonderry/Derry, BT48 7JL**

**Re: Research Project title: Pilot evaluation of low-intensity CBT in Northern Ireland :
Exploring the perspectives of service users**

Dear Sir/Madam,

You are being invited to participate in a research study. This relates to the treatment you received from the trainee Psychological Wellbeing Practitioners (PWP) who have been working within your service. In order to evaluate how effective this service is, it is important that we hear about the experiences of those who have used the service. This will help to increase awareness of important and current mental health service issues in Northern Ireland, and inform service development going forward.

What is the purpose of this research study?

This study will explore the perspectives and experiences of service users who have been treated by a trainee PWP. The aim is to find out what your perspectives are in relation to the service provided and, in relation to accessing mental health care in Northern Ireland. The information gathered from this research, will help to further understanding about what you have experienced. This will also help to inform others working in this field, specifically those who are developing strategies to improve access to treatments and those working in therapeutic services.

What does participation involve?

The study involves taking part in an interview which should take 60-90 minutes. It will be audio-recorded and arranged to suit your schedule. It is up to you to decide whether or not to take part. If you decide to participate, you will be given this information sheet to keep. You will also be asked to sign a consent form. You can change your mind at any stage in the process and withdraw from the study without giving a reason. During the interview, you may ask for the tape to be switched off and the contents erased. After the interview has

been recorded, you may also later decide that you would not like your material to be included in the study.

Confidentiality

All information and material collected will be kept confidential and securely stored in Ulster University for up to 10 years; after which all data will be permanently erased. I would like to quote ad verbatim from the interview in future publications or presentations but this will not happen without your permission. Any information collected will be published in such a way that it cannot be identified with you personally. Your name or identifying information will never be used in any report arising from this study. Confidentiality will only have to be broken if it is believed someone is at risk of harm.

Thanking you most sincerely for taking the time to read this letter,

Kind regards,

A handwritten signature in black ink that reads "Karen Kirby". The signature is written in a cursive style with a horizontal line underneath the name.

Dr Karen Kirby, PhD, Chief Investigator, Lecturer of Psychology, Ulster University.

Email: k.kirby@ulster.ac.uk

Tel contact: 028 71 67510

Appendix K



Participant Consent Form Project title: Pilot evaluation of low-intensity CBT in Northern Ireland: Exploring the perspectives of service users

1. I confirm that I have received the information sheet for the above study and I have read and understood it and have asked and received answers to my questions raised.

Please tick: ☐

2. I am aware that my participation is voluntary and that I can withdraw from this study at any time, for any reason, without adverse consequences.

Please tick: ☐

3. I understand that all information and data collected will be kept confidential and stored securely and that confidentiality will be upheld at all times.

Please tick: ☐

4. I understand that all efforts will be made to ensure that I cannot be identified personally as a participant in this study (except when someone is at risk of harm to themselves or others, in which case, help will be sought immediately).

Please tick: ☐

5. I agree to take part in this study.

Please tick: ☐

6. If for any reason I become concerned or need more information about this study, I know that I can contact the chief investigators below.

Please tick: ☐

Participants name (Printed): _____

Participants Signature: _____

Please note that your signature here will be kept separate from the anonymised data, so that your identity is protected.

Signature of research team member : _____

Date: _____

Chief investigator: Dr Karen Kirby
675109

Email: k.kirby@ulster.ac.uk.

Tel: 028 71

Appendix L

Dataset

Variable Names	Values	Variable Labels
Site	1.00	Healthy Living Centre
	2.00	Foyleside Family Practice
	3.00	Bridge Street Practice
	4.00	Korum Centre
	5.00	Kalms
	6.00	Belfast Trust
	7.00	Western Trust
	8.00	Southern Trust
	9.00	Aware Derry
	10.00	Aware Belfast
	11.00	Mens Action Network
	12.00	People Plus N.Irl
Referral method	1.00	GP
	2.00	Self
	3.00	Primary Care Team
	4.00	Hub
	5.00	Employment Consultant people plus
Assessment arranged	1.00	yes
	2.00	no (attempts to contact unsuccessful)
	3.00	no (not interested in service)
	4.00	no (unsuitable for low intensity service,step up recommended)
1 st session arranged	1.00	next contact agreed and attended
	2.00	next contact agreed but did not attend
	3.00	stepped up to higher intensity service
	4.00	referred to another low intensity service

	5.00	client declined further sessions
Gender	1.00	female
	2.00	male
Baseline employment	1.00	employed or full time student
	2.00	unemployed
	3.00	retired
	4.00	sick leave
	5.00	not known
Discharge employment	1.00	as baseline employed
	2.00	as baseline unemployed
	3.00	as baseline retired
	4.00	as baseline sick leave
	5.00	planning a return to work
	6.00	has returned to work
	7.00	commenced further education
	8.00	not asked
	9.00	voluntary redundancy
Marital status	1.00	married/cohabiting/in relationship
	2.00	single
Presenting problem	1.00	depression
	2.00	general anxiety
	3.00	comorbid depression and anxiety
	4.00	specific phobia
	5.00	panic disorder with agoraphobia
	6.00	panic disorder without agoraphobia
	7.00	health anxiety
	8.00	primary symptoms indicate post-traumatic stress
	9.00	depression associated with chronic physical pain
	10.00	Obsessive compulsive symptoms

	11.00	social anxiety
Diagnosis group	1.00	mood diagnosis
	2.00	anxiety diagnosis
	3.00	comorbid mood and anxiety diagnosis
Onset	1.00	onset of current issues within the previous 1 to 6 months
	2.00	onset of current issues within the previous 7 to 11 months
	3.00	onset of current issues within the past 1 to 2 years
	4.00	onset of current issues within the previous 3 to 5 years
	5.00	onset of current issues within the previous 6 to 10 years
	6.00	onset of current issues within the last 11 to 15 years
	7.00	onset of current issues within the previous 16 to 20 years
	8.00	onset of current issues within the previous 21 to 30 years
	9.00	onset of current issues within the previous 31 to 40 years
	10.00	onset of current issues within the previous 41 to 50 years
	11.00	onset of current issues not specified or undetermined
Current risk	.00	no current risk
	1.00	current suicidal ideation
	2.00	current suicidal plans
	3.00	recent suicidal behaviour
Previous risk	.00	no previous risk
	1.00	previous suicidal ideation
	2.00	previous suicidal plans
	3.00	previous suicidal behaviours

Risk to others	.00	No
	1.00	Yes
Previous risk to others	.00	No
	1.00	Yes
Neglect	.00	no neglect
	1.00	self-neglect
	2.00	neglect of others
	3.00	neglect of self and others
Medication use	.00	No
	1.00	Yes
Medication type	1.00	yes on med(s) but type/name not recorded
	2.00	anti-depressant med(s) only
	3.00	anti-anxiety med(s) only
	4.00	anti-depressant and anti-anxiety med(s)
	5.00	anti-psychotic med(s) only
Medication concordance	1.00	taking as prescribed
	2.00	not taking as prescribed
	3.00	not asked
Medication continuation	1.00	continued
	2.00	discontinued
	3.00	not asked
Substance use	.00	Client declined to declare usage or the info was not recorded
	1.00	Declared no current use of alcohol or drugs
	2.00	Current use of alcohol only
	3.00	current use of drugs only
	4.00	current use of alcohol and drugs
	5.00	no current use of alcohol or drugs but history of alcoholism declared
History of difficulties	.00	No
	1.00	Yes
Description (if history)	1.00	Depression

	2.00	General anxiety
	3.00	comorbid depression and anxiety
	4.00	Specific phobia
	5.00	Panic disorder with agoraphobia
	6.00	panic disorder without agoraphobia
	7.00	Health anxiety
	8.00	Post-traumatic stress symptoms
	9.00	Addictions
	10.00	anger management difficulties
	11.00	social anxiety
Type (if history)	1.00	mood diagnosis
	2.00	anxiety diagnosis
	3.00	comorbid mood and anxiety diagnosis
Previous treatments	.00	No
	1.00	Yes
Description (if yes to above)	1.00	Antidepressant medications
	2.00	Anti-anxiety medications
	3.00	Unspecified medications
	4.00	Counselling
	5.00	CBT
	6.00	Computerised CBT
	7.00	Group CBT
	8.00	Support Group
	9.00	Unspecified psychological therapy
	10.00	Psychiatric Services
	11.00	Support group and individual counselling
	12.00	Support group and individualised psychological therapy
	13.00	CBT and counselling
	14.00	CPN (Community Psychiatric Nurse)

Type (if yes above)	1.00	medication(s)
	2.00	talking therapy
Other treatments	.00	No
	1.00	Yes
Description (if yes above)	1.00	Generic counselling
	2.00	Eating Disorders Clinic
	3.00	Learning Disability Service
	4.00	Adult autism spectrum services
	5.00	AWARE support group
	6.00	Occupational therapy and support group
	7.00	CPN (Community Psychiatric Nurse)
	8.00	Nexus
	9.00	Mindfulness course
	10.00	Psychiatric services
	11.00	Exercise programme and psychiatric services
Duration of LICBT	1.0	1 session
	2.0	2 sessions
	3.0	3 sessions
	4.0	4 sessions
	5.0	5 sessions
	6.0	6 sessions
	7.0	7 sessions
	8.0	8 sessions
	9.0	9 sessions
Caseness	1.00	Case
	2.00	Non-case
PHQ-9 session 1 item 1	.00	Not at all
	1.00	Several days
	2.00	More than half the days
	3.00	Nearly every day
PHQ-9 session 1 item 2		Labels the same for all items
PHQ-9 session 1 item 3		Labels the same for all items

PHQ-9 session 1 item 4		Labels the same for all items
PHQ-9 session 1 item 5		Labels the same for all items
PHQ-9 session 1 item 6		Labels the same for all items
PHQ-9 session 1 item 7		Labels the same for all items
PHQ-9 session 1 item 8		Labels the same for all items
PHQ-9 session 1 item 9		Labels the same for all items
GAD-7 session 1 item 1		Labels the same for all items
GAD-7 session 1 item 2		Labels the same for all items
GAD-7 session 1 item 3		Labels the same for all items
GAD-7 session 1 item 4		Labels the same for all items
GAD-7 session 1 item 5		Labels the same for all items
GAD-7 session 1 item 6		Labels the same for all items
GAD-7 session 1 item 7		Labels the same for all items
Data collected as above for 11 sessions (both PHQ-9 and GAD-7)		
Discharge information	1.00	discharged following treatment completion
	2.00	discharged due to requirement for higher intensity service
	3.00	discharged as already receiving higher intensity treatment
	4.00	discharged due to nonattendance and unsuccessful attempts to contact
	5.00	discharged due to referral to another low intensity service
	6.00	client declines further sessions
Follow up consent	1.00	eligible to consent and consent given
	2.00	ineligible to provide consent due to timings of ethical approval
	3.00	eligible to consent but consent withheld
	4.00	ineligible to provide consent due to treatment incompleteness following step up referral

	5.00	consent not sought as client dropped out of service prior to consent being sought
	6.00	ineligible to consent as site withheld consent for follow-ups
Follow up completed	1.00	follow up completed
	2.00	follow up not completed as client uncontactable
	3.00	follow up not completed as client changed mind
	4.00	not applicable as consent not obtained

Follow-up data collected for 1 PHQ-9 and 1 GAD-7, labels identical to sessional data.

Depression baseline severity	.00	non-clinically relevant symptoms
	1.00	clinically relevant symptoms
Anxiety baseline severity	.00	non-clinically relevant symptoms
	1.00	clinically relevant symptoms
Depression end severity	.00	non-clinically relevant symptoms
	1.00	clinically relevant symptoms
Anxiety end severity	.00	non-clinically relevant symptoms
	1.00	clinically relevant symptoms
Reliable deterioration dep	.00	no reliable deterioration
	1.00	reliable deterioration
Reliable improvement dep	.00	no reliable improvement
	1.00	reliable improvement
Reliable deterioration anx	.00	no reliable deterioration
	1.00	reliable deterioration
Reliable improvement anx	.00	no reliable improvement
	1.00	reliable improvement
Overall reliable deterioration	.00	No overall deterioration
	1.00	overall reliable deterioration criteria met

Overall reliable improvement	.00	No overall reliable improvement
	1.00	reliable improvement criteria met
Overall reliable recovery	.00	No overall reliable recovery
	1.00	Overall reliable recovery criteria met
Severity session 1 (dep)	.00	minimal depression
	1.00	mild depression
	2.00	moderate depression
	3.00	moderately severe depression
	4.00	severe depression
Symptom severity information recorded as above for 11 sessions including baseline, final and follow-up (variable value labels the same for all)		
Severity session 1 (anx)	.00	mild anxiety
	1.00	moderate anxiety
	2.00	moderately severe anxiety
	3.00	severe anxiety
Symptom severity information recorded as above for 11 sessions including baseline, final and follow-up (variable value labels the same for all)		
age_cat	1.00	18-30
	2.00	31-40
	3.00	41-50
	4.00	51-64
	5.00	65-77
Anxiety latent classes	1.000	Improvers
	2.000	Non-improvers
Depression latent classes	1.000	Improvers
	2.000	Non-improvers
Gender (binary recode)	.00	male
	1.00	female
Employment (binary recode)	.00	employed
	1.00	unemployed
Risk (binary recode)	.00	no current risk

	1.00	some level of current risk determined
Medication (binary recode)	.00	no
	1.00	yes
Onset (binary recode)	.00	within last 5 years
	1.00	ongoing for more than 5 years
Neglect (binary recode)	.00	no neglect determined
	1.00	some level of neglect determined
Previous treatments (binary recode)	.00	no
	1.00	yes
Concurrent treatments (binary recode)	.00	no
	1.00	yes
Comorbidity (binary recode)	.00	no
	1.00	yes

Appendix M

Semi -structured interview Schedule (service providers)

1. Can you tell me what you think about the Psychological Wellbeing Practitioner service?
2. Can you tell me about your experiences/perspectives of the delivery of low intensity interventions, provided to clients in your service?
3. How would you describe the impact the PWP has had within your service?
4. What do you think are the most important issues to address in mental health care in Northern Ireland?
5. What do you feel are the most important issues around *improving access* to psychological therapies in Northern Ireland?

Probes

- Could you tell me some more about that?
- What did you think about that?
- How did that make you feel?
- Could you give me some more examples of that?
- Could I go back to something you mentioned earlier...you said _ could I ask you a bit more about that
- You mentioned that _ could you explain a bit more about what you mean by that

Appendix N

Sample interview transcript

Interview 2 EP

How have you found the PWP service within CALMS (your service) e.g. what benefits if any do you think it has had?

I think it was a journey that initially evolved..like every new service we were teething it in. And, we never ever had any issues with any of the PWPs that came through. They were all of a high calibre, a high standard. The teething in would've been because we used the PWPs alongside the Hub, and then alongside calms policies and procedures although it would have been training them up as well on our policies and procedures, regulations of the Hub. We would have had teething problems but we have had a positive journey with the PWPs and I think it was only of benefit to Calms, because it has been helping us develop a social economy side where we're not going to be totally dependent on the voluntary sector for funding. However, we haven't attracted any core funding yet. But considering a PWP I just think the timeframe with them is excellent as well in the sense that you have a higher turnover of people in a shorter period of time and they are very specific on what they can work on so it's been a positive journey but the organisation is growing with the PWPs, so its evolving and for me it's only been positive; I think it's an excellent service at that stepped care level for the clients.

I think if you get what the PWP can do and offer ...that if we could get more awareness of what a PWP is out there, you could maybe have a lot of prevention as well. I see them very much as psychosocial educational. You know general wellbeing for the clients. So while we are working with TT and the Hb, I don't think there is a great awareness in the community. I mean, I wouldn't say to someone we can send you to a PWP because it's not really a comfortable word out there in the community yet in the sense that someone knows what a counsellor is, someone knows what a complimentary therapist if. But I mean we are evolving and I think it is now about raising awareness that a PWP can work at that level of intervention for step 1 and step 2 but is how we raise awareness. The university and Calms. But yes, it is an excellent service for someone that doesn't need to go into counselling and I think a very cost effective service.

If you look at how MH services are structured now in NI...what do you think needs to happen in order to improve access to psychological therapies?

Well that's a good question. This isn't off on a tangent, and in some way is related to your question but I was driving to work today, and I was just trying to get an appointment with a GP for someone, and there was anger when I came off the phone because there were no appointments. But, can I just say first of all that that's not negative. I am not saying negative things about the GHPS because the first thing that came up in my head was burnt out GPs burnt out receptionists, tired and frustrated patients, burnt out professional carers, trying to get appointments for people, and I

thought, this NHS is falling apart. And just listening to the news as well last night about a few things that were on it; I honestly don't; know because right now we don't even have a functional government, we have no one sitting in Stormont, so we can write whatever paper we want, we can suggest whatever we want to do, but there is no health minister for NI right now. But, I think it has to be collective and I think that the voluntary sector in my experience (since 1994) has always been treated like the Cinderella sector and it's been a supping ground and I get quite frustrated with myself coming from the statutory sector I can see how they dump with very little respect and I'd go as far to even say that there is a lack of respect even when you're ringing them for a query. But the only way it can be done is a joined up approach but it has to be where everyone values and respects everyone's opinion, where they're coming from.

I honestly don't know regarding the SC model right now. I mean we are all about prevention and I'm going right back to when the NHS was set up, it was about prevention but now you can even see that they're not releasing certain drugs because it's all about budgets, so I don't know, I get frustrated even in this sector myself. I think we all have to be on the one team, and we have to all be on an even playing field, and we have to stop this competitiveness that funders put on and outputs..its all about quantity now and its all cost effectiveness rather than wellbeing. I'm interested in the whole thing around resilience,. I mean I do think this is where a PWP can save money and I do think its about early counselling prevention and getting to someone before they are on any medication, and all of us evaluating is this working is this what the person needs? But it's going to take us all sitting down together.

Access is pretty difficult. I mean if someone rang me today to this organisation, say they knew PWPs were out there.... And said could I have an appointment with a PWP, the answer is no...you need to go to your GP, your GP needs to make a referral, and that referral can take 6-12 weeks, and then it may not be referred to CALMS it may be referred to another organisation. Because our budget comes from the hub, and we had this happen on many occasions. Someone rings up and says you do LICBT, can I get an appointment ...no you have to go to your GP. **Yes I had this discussion with someone else also...the referral pathway as it is, is kind of blocking access.....**and I think this is very much about a fear culture as well. Because we're all frightened, community projects are fighting for survival and it is survival of the fittest, and no longer just applications, its business plans with limited human resources to do them. There is no money in the VS to bring someone in to a business plan. But I also think from the Boards perspective of TT, if someone was able to refer directly, then what happens to the coordinator, does their post or job.. so there is a fear also of letting the person self-refer. Also, how do you control that, who pays for that? So no, there is no clear pathway on how you can access PWP services in NI. And I would say even for the people who have come through here, if you asked them, were you with a PWP, they might not know, they might say they had a service but think they have seen a counsellor. It's not out there. Whereas in Newcastle (Eng) they are everywhere and it's a buzz word. But nobody here no one knows them or what they do, even though Calms is very successful. It's not a word you see. You know the way you would lift a leaflet and it might say, are you stressed etc we offer

counselling. You don't; see leaflets in NI, saying we offer PWP..I would say its not even 5% marketed in NI yet. Now that's not negative because I want to say I see them really having a positive contribution in there with counsellors, therapist, wellbeing practitioners. Whatever...but I don't think the PWP is marketed at all in NI.

One of the things I also think would be of great benefit is...which I don't think is promoted enough at the stepped care level or in terms of interdisciplinary workings, is that PWPs instead of just working one on one could be doing programmes which is something that I would like to look at. I think we could be going in to places like call centres and that and taking resilience tools in for prevention because we see that a high volume of our clientele would be working in call centres. So there's a market there too for companies to see the benefit of PWP services for the wellbeing of their staff.

I think something has to change generally (with the structure of services)...everyone is burnt out right now in the health service.. to get access to any service at the minute....I mean for someone to get tested for autism or ADHD, some of the waiting is up to three years, and six months at the least. So, it is going to take a lot of restructuring. I think what they were set up to do..the NHS.. was normally about prevention but now people are ready to keel over before they are getting access to services. I agree with M...they are not getting the service they need in time, so they are deteriorating. I mean some of the referrals that we would see here are bad because of the delay, and quite a few that has had the PWP we have then had to say to use out other project for counselling free of charge. Now to validate that or correlate that ... did the delay in the service access bring that on? Or was it something that was about to awaken anyway? Did the PWP give them the strength to walk the other walk and go into counselling? I don't know...that would need some kind of comparison but...I mean the delay...if you have toothache you want it dealt with there and then, so for the PWP to work time is of the essence.

I would be very clear about the professionalism and the quality of the people being turned out by the university is excellent. the service in the room is excellent and our evaluation in house and elsewhere...the research tells us its working. The problem is how is it marketed? How do people access it? How do we raise awareness and how do we get all the key players on board?

