

## Chapter 1

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# Low intensity CBT interventions: a revolution in mental health care

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### Introduction

It is no exaggeration to say that mental health care in primary health settings worldwide is at the start of a revolution that will change the shape of health care practice in the next two decades. We are at the birth of a new era—a new era in the development of evidence-based psychological therapies, a new era in the delivery of mental health services, a new era oriented towards the promotion of psychological wellbeing on a community-wide basis.

A careful examination of the literature indicates that the seeds have been germinating in different ways in different places over the past 30 years:

- ◆ The drive to develop briefer, more cost effective psychological treatments
- ◆ The dissemination of evidence-based practices to mental health professionals from varied backgrounds
- ◆ The development of self-help books based on cognitive behavioural therapy (CBT) principles
- ◆ The innovation of ‘guided’ self-help
- ◆ The growth of the internet
- ◆ Clinical trials of internet-based CBT and self-help manuals
- ◆ Various other high volume approaches to CBT (e.g. group CBT, brief therapy, population-based stand alone internet programs)
- ◆ New ideas about health delivery systems (e.g. stepped care, collaborative care)
- ◆ The move towards a patient-centred orientation
- ◆ The use of remote communication technologies for therapeutic purposes (telephone, email, SMS, internet)
- ◆ Government recognition not only of the human misery of depression and anxiety, but of the economic and productive loss to society
- ◆ Latterly, clinical trials of new *low intensity* forms of health care delivery.

All have suggested that we can ‘democratize’ CBT and make it more available to the vast numbers of people who suffer with mental health problems.

Highly qualified mental health professionals are a finite and often scarce resource. Extending traditional one-to-one psychotherapy to the whole population is not a viable option. So, in order to achieve greater access to evidence-based treatments, we have had to find ways to achieve similar outcomes with much lower intensity interventions. Along the way, we have discovered that a previously unquestioned assumption amongst therapists—that everyone would want one-to-one therapy if given the choice—turns out to be largely misplaced. Some people actually *prefer* low intensity options, such as self-help books, internet-based CBT, advice clinics, and large group education classes (Marks and Cavanagh 2009; White, Chapter 3).

The term ‘low intensity’ has only come into usage recently (Bower and Gilbody 2005; Haaga 2000; Lovell and Richards 2000; Richards and Suckling 2008, 2009), and at the time of writing is largely unused outside of the UK. Low intensity (LI) refers to low usage of ‘specialist therapist time’ (Bower and Gilbody 2005), or usage in a cost effective way (e.g. in group CBT context). When we came to write this book, we realized that there was no common understanding of what LI interventions might be, nor was there an existing definition. This was scarcely surprising, because one of the purposes in creating the book was to bring a varied assortment of LI approaches together under one umbrella, and to see whether a common understanding and definition could emerge. What did exist was a disparate literature of LI-type CBT approaches scattered around a considerable array of journals. Amongst these, the common thread was an endeavour to increase access, efficiency, and cost-effectiveness. Although the English Improving Access to Psychological Therapies (IAPT) program, and similar initiatives in Scotland, has begun to knit some of these threads together, there is still a lot of weaving to be done to arrive at a shared understanding of what LI CBT interventions are about. Not everyone will agree with our definition; some will dispute that all the chapters in this book qualify as ‘low intensity’. No problem. In true scientific spirit, we confidently expect that definitions will be refined in time to come, and there will be additions and deletions from future editions of this book.

What is clear is that we are ushering a new paradigm into our mental health systems—one that will continue to evolve. This is the most radical re-think in mental health services since the large scale closure of psychiatric beds and transfer of seriously mentally ill patients to non-institutional forms of care in the community (Thornicroft and Bebbington 1989). As with the introduction of any new paradigm, there have been fierce debates and trenchant criticisms (ironically not dissimilar to the kinds of critique that behaviour therapists faced from psychotherapists in the middle of last century!). What the critics tend to overlook is that, until recently, the choice for people with high prevalence disorders (depression and anxiety) in most countries was stark—nothing or medication; or, for the fortunate, long waiting lists for public services or private therapy if available and affordable. Nobody is suggesting that LI interventions are the panacea for all ills. What we are beginning to see is that they can be effective treatments for many people with high

prevalence disorders, and that the range of people that can access evidence-based treatments is now vastly increased.

As the next four chapters by Richards (Chapter 2), White (Chapter 3), Christensen (Chapter 4), and Williams and Morrison (Chapter 5) illustrate, LI CBT is all about finding ways to increase access to effective treatments for all sectors of society, including the most vulnerable and hard to reach (see Kavanagh and Deane, Chapter 56; Laliberte *et al.*, Chapter 62; Lau, Chapter 60; Leibowitz, Chapter 61; White, Chapter 58). However, the shift to the LI paradigm involves much more than simply developing new ways to package CBT to increase access. It also involves:

- ◆ New models of health care
- ◆ The development of new services
- ◆ New ways of working and new workforces
- ◆ New ways of training and supervision
- ◆ New ways of engaging the public
- ◆ New ways of communicating about CBT.

We are now at an exciting stage where LI CBT has moved out from the research laboratory, and from pilot projects at the periphery of health systems, to roll-out in clinical settings on a national scale, and population-based early intervention and prevention strategies.

The rest of this chapter is divided into five sections. In the first section, we review some of the historical antecedents for the development of LI CBT. In the second section, we provide a definition of LI CBT, and the thinking behind its development. In the third, we focus on how LI CBT has vastly increased patient choice; in the fourth, we illustrate some of the changes in philosophy and practice that contribute to the new paradigm; and in the fifth, we draw conclusions about the place of LI CBT interventions in the health care system.

## Historical antecedents of low intensity CBT

Within the world of evidence-based psychological therapies, CBT is currently the dominant therapeutic model. Although other evidence-based therapies exist, the sheer breadth and depth of empirical support for CBT makes it the first non-pharmacological choice for many psychological difficulties. It was not always thus. Indeed, even the concept of an evidence-base being applied to psychotherapy is a fairly recent development, beginning with work by Joseph Wolpe, Hans Eysenck, Monte Shapiro, and, of course, A. T. Beck during the 1950s and early 60s.

The early pioneers of CBT faced an uphill struggle and were often reviled for their views. Proponents of established psychotherapies tended to hold rigid antagonistic beliefs. The way the early CBT pioneers chose to counter these beliefs was to harness the scientific method to their studies. This they did with great relish. For example, up until the mid-1960s, it was widely believed by the Freudian school that the compulsive behaviour seen in obsessive

compulsive disorder (OCD) was an outlet for self-loathing and that any attempt to interfere with this behaviour would lead to severe internalized aggression as a form of 'symptom substitution'. A well-designed study by Isaac Marks undertaken for his MD studies showed conclusively that patients with obsessive-compulsive disorder do not in fact use their symptoms to defend themselves against aggression (Marks 1965).

Other studies accumulated, demonstrating that most anxiety disorders could be treated successfully without the predicted appearance of compensatory symptoms. Scientific work in the USA and then elsewhere showed that techniques to help people think differently about themselves, their difficulties, and their world could lead to successful amelioration of both anxiety and depression. Behaviour therapy and cognitive therapy combined their empirical strengths and became CBT.

However, the health care world was not yet ready for the routine application of science to psychological therapies practice. It was not until the 1990s, when 'evidence-based medicine' (EBM) was born, that the efforts of these pioneers and their successors became truly appreciated. The scale of this transformation has been breathtaking. For example, in 1975 there were 421 members of the UK's CBT organization, the British Association of Behavioural and Cognitive Psychotherapies (BABCP: <http://www.babcp.com>). In 1997, after more than 20 years of research, this had only risen to 2000 people. However, the increasing influence of EBM ideas and their translation into evidence-based clinical guidelines, such as those produced by the UK's National Institute for Health and Clinical Excellence (NICE), has seen the membership quadruple to over 8000 in 2009. There have been similar transformations internationally, with the growth of national CBT organizations and training programs across all continents.

Widespread acceptance brings a heavy burden. The availability of CBT has always fallen way short of need. Too few trained practitioners, too few training courses and an adherence to traditional delivery methods has severely limited access. With CBT in the mainstream of healthcare, new ways of ensuring its availability have become critical.

Such concerns are not new. The early pioneers of CBT did not believe that lengthy courses of intensive psychotherapy were necessary for effective relief of suffering. Their new treatments were brief and to the point when compared with the existing psychotherapy models. It was an article of faith amongst these researchers that CBT treatments should be efficient as well as effective. This drove many to investigate ways of making CBT even more available.

As a consequence, pioneers such as Isaac Marks made it their business to make CBT-based information available in as many different and accessible forms as possible. Marks regarded the essentially technique-driven clinical protocols of CBT as eminently suitable for public dissemination. Unlike the mysterious processes involved in many competing schools of psychotherapy, CBT had a clarity which could be easily explained. Marks published one of the first and most widely translated CBT self-help books, *Living with Fear* (Marks 1978). Other books rapidly followed, ensuring that CBT information became available in libraries and bookshops throughout the world. Another landmark publication was the *Clinician's Guide to Mind over Mood* (Padesky and Greenberger 1995), the lesser

known companion book to the popular self-help manual *Mind over Mood* (Greenberger and Padesky 1995). Here, for the first time, was a detailed manual specifically written for clinicians to provide *guided CBT*.

The lack of skilled CBT therapists has been a constant limitation—never enough to meet demand. In the UK the BABCP has been avowedly multi-disciplinary. During the 1970s, Marks persuaded the UK government to experiment with training nurses to deliver CBT, a radical and revolutionary idea at the time (Marks *et al.* 1977). He was successful by showing that patient outcomes were just as good when nurses delivered CBT compared with other professionals (Marks 1985).

We have come a long way since those early days, but the idea of evidence-based information being supported by specifically trained mental health workers persists in the CBT consciousness. The definition of LI CBT we use in this book owes much to principles of efficient delivery through making information available in self-help formats, and by using practitioners who are not necessarily specialist ‘high intensity’ CBT therapists. Along the way, new technologies have offered a helping hand. The internet is revolutionizing mental health care, enabling CBT treatments to be delivered worldwide without people having to leave their homes (Marks *et al.* 2007). Email, phone, SMS, and internet applications, such as bulletin boards and chat rooms offer further flexibility.

Ironically, the target is no longer to reduce the time required for effective psychological therapies from 2 or 3 years of intensive psychotherapy, but from 12 to 20 sessions of high-intensity CBT. Most importantly, now that we have psychological treatments that in some cases have been shown to be more effective than the pharmacological alternatives, LI CBT therapists worldwide are working hard at making them available to all who need them.

## Low intensity CBT: towards a definition

In this section, we discuss considerations that led towards the development of our definition of LI CBT. When we started the book, there was no existing definition. Arriving at a definition that encompassed the key elements of LI CBT proved a stimulating, as well as a challenging task for the editors. We saw it as central to the enterprise to create a definition about which there was consensual agreement.

Looking at the history of the terms ‘low’ and ‘high’ intensity CBT, they appear first to have emerged at the start of this century in relation to stepped care: the idea that *less intensive* CBT therapies should be offered alongside *more intensive* therapies (Bower and Gilbody 2005; Haaga 2000; Lovell and Richards 2000). Bower and Gilbody (2005) listed several examples of *less intensive* treatments, including brief therapies, group treatments, self-help approaches, such as bibliotherapy, and computerized treatments. All of these approaches are covered in the present book. They suggested that the main candidate for stepped care was CBT, due to its strong evidence-base and the fact that there could be consistency of approach across low and high intensity steps. Consequently, LI CBT came to signify forms of CBT treatment that limited specialist therapist time, or used this time

in a highly cost effective manner (e.g. in group CBT). Within the context of the first UK clinical study (Richards and Suckling 2008, 2009), LI CBT was known as *High Volume, Low Intensity* CBT. In this book we have shortened the term to ‘low intensity CBT’, in recognition of the fact that most, but not all, LI CBT involves *high volume*. An exception to the high volume rule would be LI CBT delivered to sparse populations in remote communities (see Lau, Chapter 60; Laliberté *et al.*, Chapter 62). Above all, what binds LI CBT approaches together is *high access*.

Our definition of LI CBT is provided in Box 1.1. Increasing access to evidence-based psychological therapies takes pride of place. One of the main ways to increase access is to reduce specialist therapist time. Therefore the definition highlights that providers of LI treatments can be a variety of practitioners: specifically trained LI practitioners (sometimes without prior formal qualifications in health), as in the English IAPT system (see Telford and Wilson Chapter 50); mental health workers from varied professional backgrounds in non-government organizations or the health system (see Khayat, Chapter 57; Williams *et al.*, Chapter 47); GP practice nurses (see Ekers, Chapter 45); GPs (see David, Chapter 36; Bilsker and Goldner, Chapter 48); peer supporters (see Lawn *et al.*, Chapter 46); psychologists in training (see Austin *et al.*, Chapter 49); or specialist CBT therapists, who are applying CBT in cost effective ways such as one session advice clinics (see White, Chapter 35); patient-led approaches to treatment (see Carey, Chapter 34) or CBT in groups (see Chellingsworth *et al.*, Chapter 20; Sochting *et al.*, Chapter 33; White, Chapter 32; Cuijpers, Chapter 38; Clarke, Chapter 40; Lau, Chapter 43).

### Box 1.1 Low intensity CBT interventions: definition

The primary purpose of low intensity CBT interventions is to increase access to evidence-based psychological therapies in order to enhance mental health and wellbeing on a community-wide basis, using the minimum level of intervention necessary to create the maximum gain. Low intensity CBT interventions have been mainly developed in the context of patients with mild to moderate psychological disorders, enabling high intensity CBT to be reserved for patients with more severe disorders. Therefore, compared with high intensity CBT, low intensity interventions:

- ◆ Reduce the amount of time the practitioner is in contact with individual patients—whether this is reduced through seeing more than one patient at the same time (i.e. group CBT); *or* seeing them for fewer/shorter sessions (i.e. advice clinics); *or* supporting their use of self-help materials (i.e. self-help books, internet-based CBT interventions); *or* facilitating their engagement with community and voluntary resources *and/or*
- ◆ Use practitioners specifically trained to deliver low intensity CBT, who may not have formal health professional or high-intensity CBT qualifications, e.g. paraprofessionals, peer supporters, voluntary sector *and/or*

**Low intensity CBT interventions: definition** (*continued*)

- ◆ Use CBT resources whose content is often less intense (self-paced, own time, bite-size pieces) *and/or*
- ◆ Provide more rapid access to early intervention and preventive CBT programs.

Low intensity CBT interventions aim to communicate key CBT principles in accessible ways, and to deliver content in a variety of flexible forms—e.g. face-to-face, email, groups, phone-based—which maximize the opportunity for patient choice. Typically, low CBT intensity interventions are simple and brief. They focus on the use of CBT self-help materials and techniques, emphasize the value of between-session homework, and assess, monitor and evaluate progress as an intrinsic part of the intervention. The content may constitute a treatment intervention in itself (e.g. behavioural activation, internet-based therapy, guided CBT), may support or promote an intervention (e.g. motivational enhancement, ‘10 minute CBT’ GP consultations, advice clinics), or may be preventive of treatment interventions (preventive/educational programs).

Compared with traditional services for patients with mental health problems, low intensity CBT interventions increase:

- ◆ Access and/or speed of access to treatment
- ◆ The total number of people who can access evidence-based treatments
- ◆ Service flexibility, responsiveness, and capacity
- ◆ Patient choice
- ◆ Cost-effectiveness of services

While in some variants of LI CBT, the practitioner’s role is largely to support the use of guided CBT delivered through written materials or the internet, LI practitioners nevertheless require basic skills in CBT so that the support can be effective. If a patient phones up distressed at the idea of an anxiety-provoking exposure session, the LI practitioner needs some core CBT skills to provide useful assistance. Hence, our LI definition encompasses the provision of specific CBT skills such as behavioural activation (see Richards, Chapter 12), problem solving (Mynors-Wallis and Lau, Chapter 13), exposure (Titov *et al.*, Chapter 15), motivational enhancement (Hides *et al.*, Chapter 16) and treatment of sleep disorders (Vincent and Holmqvist, Chapter 17), as well as understanding about the importance of physical activity for depression (see Taylor, Chapter 14). Similarly, LI practitioners may make use of methods which allow for communication at distance e.g. phone (see Lovell, Chapter 27), SMS (Shapiro and Bauer, Chapter 28), email (Titov Chapter 29), bulletin boards (Griffiths and Reynolds, Chapter 30), and conventional mail (Kavanagh *et al.*, Chapter 31), either singly or in combination (Andersson and Carlbring, Chapter 26).

Assessment, monitoring, homework and evaluation are key elements in LI CBT also covered within the definition (see Donker *et al.*, Chapter 23; Farrand and Williams, Chapter 6; Proudfoot and Nicholas, Chapter 7). In the English IAPT program and in some other LI services (see White, Chapter 3), signposting and linkage with other significant organizations (employment, financial, voluntary) may also be part of the LI practitioner's role.

LI CBT may be low intensity for the patient, but it is not always so. One way that LI CBT is low intensity for both for recipient and provider is that it may be delivered in self-paced, bite-size pieces; for instance, patients undertaking internet-based programs can do so at a time and pace of their choosing in their home environment. However, LI CBT can also create high intensity emotions. LI CBT groups or computer-based programs for anxiety disorders may be low intensity forms of delivery, but experienced as high intensity anxiety provoking situations. The term 'low intensity' therefore refers primarily to delivery methods, rather than the patient's experience.

Within the UK health services, LI CBT has been closely linked to *guided* CBT. At this stage, the evidence base suggests a significant advantage for *guided* CBT versus *unguided* as treatments for depression and anxiety in terms of clinical effectiveness (Gellatly *et al.* 2007; Hirai and Clum 2006). However, we cannot consider the effectiveness of LI CBT purely in terms of those engaging with clinical services. We know that there is a huge percentage of the population who for one reason or another choose not to use health services (Andrews *et al.* 2000). Some may prefer anonymity; others (e.g. those living in regions or countries poorly served by CBT) may have no means of accessing services, other than those freely available on the internet. The lowest intensity type of service are self-help books (see Farrand and Woodford, Chapter 19), and stand alone CBT delivered over the internet (see Christensen, Chapter 4; Marian and Kenardy, Chapter 39).

The internet enables early intervention and prevention programs to be offered on a massive scale. Although unguided programs may suffer from poor completion rates and weaker clinical effectiveness than guided programs (Cavanagh, Chapter 21), a free unguided internet program provides access to millions more respondents than *guided* CBT programs, which are limited by the availability of practitioners to provide guidance. What unguided programs may lose in clinical effectiveness, they may gain in extending reach to participants who might otherwise never undertake a CBT program. Their value is particularly relevant for populations and countries where guided CBT is unavailable, or where an internet user may not want contact with health professionals. We have therefore included stand alone unguided internet CBT programs within the definition of LI CBT. For similar reasons, we have extended the LI definition to include preventive CBT, as well as early intervention programs, and have included a preventive section in the book (see Section 2G).

As the evidence base grows, we anticipate further evolution in the LI clinical method itself, at times necessitating revisions of the definition. Indeed, even within this book some chapters are already beginning to make the definition 'creak at the seams'.

For example, Proudfoot *et al.* (Chapter 25) and Deane and Kavanagh (Chapter 37) both discuss applications of LI CBT interventions to patients with health disorders and more severe mental health problems (e.g. eating disorders, psychosis), which point the way to future extensions of LI CBT practice.

The choice of chapter topics has been largely guided by the definition. At the boundaries are chapters on mindfulness-based cognitive therapy groups (see Lau, Chapter 43), which are usually offered by specialist CBT therapists, but fall within the LI definition because of their relative cost-effectiveness (ratio of therapist to patient time); and preventive chapters on adolescent (see Callear *et al.*, Chapter 41) and parent programs (see Sanders and Brennan, Chapter 54), even though the book is focused on adult disorders. We acknowledge that not everyone will consider that mindfulness-based cognitive therapy or the chapters on adolescents should fall within the parameters of a book focused on LI CBT for adults.

This range of interventions points not only to a whole raft of new ways to increase access. They also increase patient choice hugely compared with just a few years ago.

### **Low intensity CBT: enhancing patient choice**

Service user participation and consumer choice have become buzz-terms for governments. The voice of service users has been an important factor in widening access and driving government moves towards LI interventions (see Seward and Clark, Chapter 51; McMahon, Chapter 52). The best clinical services provide choice, and try to match programs to patient needs (see Martinez and Williams, Chapter 9). White (Chapter 3) offers a variety of low (and higher) intensity choices in the Glasgow STEPS program, including large group education classes, advice clinics, population-based interventions, and guided self-help. He reports that people attending large group evening classes in stress control expressed a strong preference for such an approach over traditional one-to-one therapy (see White, Chapter 3). We are only slowly realizing that the high DNA (did not attend) and drop-out rates in typical health service therapy clinics (e.g. Self *et al.* 2005) may indicate that some patients may actually feel *more* comfortable with approaches other than one-to-one high therapy. Not everyone wants (or needs) high intensity.

At this stage, the English IAPT services typically offer choice *within* the steps of a stepped care model—for instance, between using internet-based programs or written materials (see Kenwright, Chapter 8; Richards, Chapter 2). Current data suggest a marginal preference for written materials (Kenwright 2008). Despite the ubiquity of the internet, written materials continue to be an attractive option, although one that should involve careful consideration. Not all self-help books are of equal value (see Farrand and Woodford, Chapter 19; Richards and Farrand, Chapter 18; Williams and Morrison, Chapter 5). Patients in some IAPT services also have the choice to attend face-to-assessment sessions or phone-based assessments; in one study in a semi-rural community, 37% opted for the latter (Kenwright 2009), presumably for reasons such as convenience, travel, cost, and perhaps in some cases the relative anonymity of phone-based assessments.

When given the choice, some patients prefer face-to-face therapy over internet-based therapy (Marks and Cavanagh, 2009), while others prefer the anonymity and convenience of internet-based treatments (Cook and Doyle, 2002; Marks and Cavanagh, 2009; Waller and Gilbody, 2009). There are suggestions that some preferences may be personality or diagnosis-based. The acceptability of internet interventions varies depending on their perceived relevance, program characteristics, design of the internet site, and stated rationale (see Ritterband *et al.*, Chapter 22; Whitehead and Proudfoot, Chapter 24) and the particulars of the client group (Proudfoot *et al.*, Chapter 25). Some internet-based participants describe the sense of freedom they feel to express themselves online without embarrassment or fear of judgment from therapists (Cook and Doyle 2002). Potentially, choice increases access. If there are some patients who are inspired to access treatment through one medium (e.g. phone or computer), but will not do so via another (e.g. face-to-face), then the offer of choice that is enabled by LI interventions may significantly enhance mental health outcomes.

However, patient choices are affected by context. The way treatments are portrayed to patients makes a difference. If patients on waiting lists perceive that they are being offered guided CBT as ‘second best’ while waiting for the ‘real thing’ (Andersson and Carlbring, Chapter 26; Cavanagh, Chapter 21; Whitfield *et al.* 2001), they show poorer uptake and do less well than patients who are offered LI interventions as the default treatment (Kenwright 2009). Enthusiastic promotion of an LI treatment by a GP is more likely to be acted on than reluctant mention by a therapist, threatened by the advent of new forms of treatment (Marks and Cavanagh 2009; Mataix-Cols *et al.* 2006). At this stage we do not know what happens if patients are offered a genuine choice between LI and HI treatments, where LI treatments are promoted with equal vigour. For instance, if potential LI CBT users heard about the value of LI treatment from peers, understood the growing evidence-base, recognized the convenience and anonymity of home-based treatment, and realized that it may be a choice between immediate access and a 3–12-month waiting list for high intensity therapy, would this impact on their choices? With data suggesting that some patients prefer LI treatments for reasons including convenience, cost, personality, perceived stigma, and personal taste, many patients may, indeed, opt for the LI option (see White, Chapter 3; Marks and Cavanagh 2009).

### **Low intensity CBT: the new paradigm**

Readers of this book who are more familiar with ‘traditional’ one-to-one therapy will encounter new concepts. As we suggested earlier in the chapter, LI CBT is not simply a change in materials. It is a change in the whole way we deliver CBT, the whole structure of health services, the whole orientation of governments and service providers. This is not evolution in any simple sense; this is revolution. The sacred cow of 50–60-minute therapy sessions delivered by highly trained psychotherapists that has persisted for over a century is being overturned. The therapy hour continues to have a place, but is now just one of a number of options.

LI CBT represents a new paradigm. Some of the components of the new paradigm seen throughout the book are:

- ◆ **New ways of working** As illustrated in the following chapters, LI CBT is delivered in a variety of ways. One of the main ways is guided CBT with support from a LI practitioner typically providing a number of short weekly support contacts for 5-8 sessions. LI CBT may also be delivered to CBT groups of various kinds (there are six group chapters in this book), and in other new non-traditional ways such as advice clinics, patient-led treatment, and stand alone (unguided) CBT delivered through the internet
- ◆ **New relationship between treatment and materials** While homework has traditionally been a feature of CBT, the relationship between the CBT practitioner, the CBT materials and the patient has radically changed with the advent of LI CBT in its guided self-help form. The CBT now largely resides *within the materials*, rather than within the therapist. It used to be said that the therapist brings to the table their expertise in CBT, while the patient brings their expertise about themselves. Now the materials bring the expertise about CBT, and the LI practitioner brings their expertise in providing valuable guidance and support—essentially communication and teaching skills
- ◆ **A new language for CBT** As Williams and Morrison (Chapter 5) have argued, the language of CBT has needed to change to make it more accessible. Gone is much of the jargon of CBT. In its place are materials designed to be inherently more attractive, relevant and interesting than some of the plodding CBT descriptions of yesteryear
- ◆ **New communication tools to deliver therapy** CBT and other psychotherapies have always been delivered face-to-face. Face-to-face has some obvious advantages (e.g. the therapist can pick up subtle nonverbal cues), but disadvantages in others, notably to do with distance, cost, access and sometimes stigma. Telephone, email, internet, SMS, bulletin boards, chat rooms, and conventional mail vastly extend the range and possibility of CBT, as noted by Christensen (Chapter 4)
- ◆ **New organizational systems** LI CBT has developed hand-in-hand with new organizational systems to deliver mental health services. As illustrated in Richards (Chapters 2 and 10), stepped care and collaborative care are central to the enhanced capacity of modern day mental health services to increase access and choice
- ◆ **New focus on efficiency and effectiveness** It is doubtful if any new mental health service has been conceived with as strong a focus on outcomes, efficiency, and effectiveness as the English IAPT program (see Richards, Chapter 2; Seward and Clark, Chapter 51; Clark *et al.* 2009). Assessment, monitoring and evaluation lie at the heart of LI CBT services (see also Smith, Chapter 55, for a Scottish example). Routine use of computers allows efficient collection of data in clinical trials, and trials of internet-based treatments
- ◆ **New focus on prevention** High volume forms of CBT delivery and efficient packaging of the ‘CBT product’ mean that for the first time programs to enhance psychological skills and wellbeing are within reach of entire communities and countries. If preventive programs can be started before adulthood (Calear *et al.*, Chapter 41), and include

parent training (Sanders and Kirby, Chapter 42), their effectiveness should be enhanced

- ◆ **New recipients of health care services** LI CBT is designed to greatly increase access to mental health services. As mentioned earlier, it seems likely that there are many people for whom one-to-one therapy was ‘too intense’ or simply unavailable, who may now be accessing LI treatments
- ◆ **New focus on service user needs** Traditional therapy is mostly a daytime activity. It takes time, money, and often time off work to come to appointments. In itself, this can serve to restrict access to patients who are financially disadvantaged, or trying to hold onto their jobs. LI CBT services tend not to be bound by working hours. The internet and books can be accessed at any time. Asynchronous email means that support can be provided the next day; patients can take phone messages at agreed times at home or in lunch hour at work. Many English IAPT services, recognizing the needs of working people, offer evening services until 20.00 hours. LI CBT has brought with it a change in focus from service provider to service user. Increasing access and patient choice underpins the LI paradigm
- ◆ **New workforce** LI CBT is now delivered in a variety of contexts by a variety of health professionals. Increasing access has led to the realization that capacity to deliver or support CBT means training new workforces. Since the CBT is ‘in the materials’ and many health professionals and lay people already have good interpersonal skills, LI CBT can be delivered—with appropriate training—by a diverse range of health, social service and community workers, by peer supporters and by members of self-help groups
- ◆ **New training** Consistent with a new and diverse workforce, LI training is now offered in a variety of ways as documented in Section 3 of this book. Training intensity depends on the role of the LI supporter, and their previous experience. It ranges from the 45 day training for IAPT LI practitioners (see Richards, Chapter 44) to the 30-minute training program for doctors in Bilsker and Goldner’s program (see Chapter 48). Perhaps not surprisingly, LI training takes advantage of new technologies: Austin *et al.* (Chapter 49) report on internet-based training for practitioners supporting internet-based CBT
- ◆ **New supervision** LI working, at least in the UK IAPT program, means supervising LI practitioners with high volumes of patients. As detailed by Richards (Chapter 11), new high volume supervision systems have been adapted from methods used by collaborative care researchers to manage this issue. With all patient data recorded on a weekly basis, cases for supervision are flagged by an automated patient data management system—for instance, the computer system will flag patients who are not improving or need a monthly review. The result is a patient-oriented system of supervision of up to 10 cases a week, a quite different model to the traditional supervisee-driven approach where supervisees ‘bring a case’
- ◆ **New services delivering CBT** Until recently, CBT has largely been delivered by mainstream health services and private practitioners (usually psychologists). The advent of

LI CBT has led to new providers entering the field (e.g. community and voluntary sectors, see Khayat, Chapter 57), with the promise of many others to come (e.g. employee assistance programs). Training and regulation may turn out to be a potential problem, but there is little doubt that the drive to ‘put CBT where people are’ will significantly increase uptake and engagement

- ◆ **New orientation of services** Driven by the imperative to increase access, LI services in the UK have engineered a radical turnaround. Traditionally, services have had long waiting lists and have been keen to divert ‘inappropriate cases’ wherever possible. LI services have the reverse orientation. They seek patients. They market their services. They strive to increase community awareness of mental health issues (see Hight *et al.*, Chapter 59), and advertise on buses, at markets, in clubs, at football games; in fact, wherever people gather (White, Chapter 3). In White’s words, LI services are ‘greeters not bouncers’
- ◆ **New orientation of governments** Governments are central to LI initiatives (see Seward and Clark, Chapter 51 on the English IAPT program, and McMahon Chapter 52 on Scottish initiatives). Without the English and Scottish governments, LI CBT in the UK would still be in the research domain. Increasingly, governments are driven by the recognition of the huge economic and social cost of the high prevalence disorders (Centre for Economic Performance 2006; Slade *et al.* 2009). They are putting service user needs at the centre of the health system, and working closely with clinicians and researchers to deliver evidence-based CBT interventions to a significantly larger section of the population.

## Conclusion

We are engaged in a revolution in mental health care, in the relationship between service users and service providers, and in the attitudes of government and society towards people with high prevalence disorders. Resources are not infinite. However, governments have realized they cannot afford—from either an economic or social perspective—to have a significant percentage of the population languishing with treatable mental health problems. Getting ‘the best bang for your buck’ has become a priority.

LI CBT offers the opportunity to vastly increase access to mental health services, to intervene early and to prevent mental health problems. LI CBT is best integrated within a stepped care framework; some people require more intensive treatments. However, as implied by recent analyses of the economic and social determinants of mental health (Wilkinson and Pickford 2009) and emphasized by White (Chapter 3), the impact of both low and high intensity CBT can be limited by social circumstances; miserable thoughts may be entirely realistic for those caught in the poverty trap. For these reasons, the IAPT program and White’s STEPS program extend the role of the LI CBT practitioner to encompass signposting and linkage to other services (e.g. employment, financial) and ‘social prescribing’ (linkage with community facilities, organizations, and interest groups). Khayat (Chapter 57) also notes how voluntary and other community organizations can facilitate this broader perspective.

As various chapters (see Richards, Chapter 2; White, Chapter 3; Seward and Clark, Chapter 51; McMahon, Chapter 52) make clear, LI CBT is as much a values-based initiative as a new way to deliver therapy. It brings people centre stage. It acknowledges that there is a lot of suffering in our communities, which has not been adequately addressed by health services. It acknowledges that mental health is just as important as physical health.

It is timely that we now have a form of psychological therapy, CBT, which can be packaged and disseminated on a mass scale, and new communication technologies to assist in the dissemination. A potentially limiting factor will be the extent to which mental health practitioners with vested interests in the 'old system' are able to adopt new practices and encompass new workforces. In the initial instance, ushering in a new paradigm requires innovators and leaders—and often thick skins! Implementing them requires government leadership, careful negotiation, demonstration of effective outcomes, and marketing to health professionals and the public.

We do not pretend that LI CBT (or high intensity CBT) will meet all needs. What we do assert is that the new paradigm offers unparalleled opportunities to extend mental health care to all sections of society for the first time in human history. The pace of change is exponential. We can be confident that chapters in future editions of this book will look very different. New technologies will evolve and offer new opportunities. The portable palm top may supplant the cumbersome desktop (or even laptop); mobile phone applications (apps) may be capable of supporting LI interventions and enable 'real time' outcome monitoring; virtual worlds may become central locations for exposure-based treatments, perhaps with support from an avatar; and just as 'CBT expertise' moved from therapist to 'the materials', so 'guidedness' may progressively move from LI practitioner to programs with sophisticated algorithms that can respond individually and appropriately to the idiosyncratic needs of people with particular kinds of disorder.

The LI CBT revolution has happened; the new paradigm is upon us. We have new ideas, new tools and new strategies to counter the dual scourges of depression and anxiety. The next stage will be more evolution than revolution. We can either snipe from the sidelines, or get on the rollercoaster. It may not always be a comfortable ride, but we have some confidence that LI CBT will make evidence-based psychological treatments available to many more people.

### Take home messages

- ◆ Low intensity CBT represents a new paradigm in evidence-based CBT practices and the delivery of mental health services
- ◆ Low intensity CBT is driven by a values-based agenda to better meet the needs of the large section of the population who suffer with depression and anxiety disorders
- ◆ Low intensity CBT vastly increases access and patient choice, with the potential for further increase as technologies develop further

**Take home messages** (*continued*)

- ◆ Elements of the new paradigm include: new ways of working, new communication tools, new organizational systems, new kinds of service, new focus on service user needs, new workforces, new training and supervision methods, and new ways of communicating about CBT
- ◆ Paradigmatic change invariably involves resistance. A judicious mix of clear leadership, well-conceived implementation strategies and responsive negotiating skills is necessary to usher in the new paradigm.

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