# A Low-Intensity Cognitive Behaviour Therapy (CBT Lite) Program Delivered by Community Mental Health Providers

Farooq Naeem, Jennifer Pikard, Muhammad Ayub, and Tariq Munshi
*Queen's University*



**ABSTRACT**

The availability of publicly funded psychological therapy for people with mental health challenges is limited in Canada and elsewhere despite evidence supporting its clinical and social benefits. We report on a pilot program of such therapy, presenting its salient features, lessons learned, and future prospects.

**Keywords:** low intensity, CBT, IAPT, Canada, CBT Lite

RÉSUMÉ

Pour les personnes ayant un problème de santé mentale, la possibilité de suivre une psychothérapie financée par des fonds publics est limitée au Canada et ailleurs, malgré que plusieurs études aient démontré les succès cliniques et les avantages sociaux de ces traitements. Les auteurs de cet article décrivent un projet pilote d'accès à ces thérapies, et présentent ses caractéristiques les plus importantes, les leçons que l'on peut en tirer et des pistes de travail pour l'avenir.

Farooq Naeem, Department of Psychiatry, Queen's University, Kingston, Ontario, and Addiction and Mental Health Services—Kingston, Frontenac, Lennox and Addington, Kingston, Ontario; Jennifer Pikard, Department of Psychiatry, Queen's University, Kingston, Ontario; Muhammad Ayub, Department of Psychiatry, Queen's University, Kingston, Ontario; Tariq Munshi, Department of Psychiatry, Queen's University, Kingston, Ontario, and Addiction and Mental Health Services—Kingston, Frontenac, Lennox and Addington, Kingston, Ontario.

There are no conflicts of interests from any of the authors. It would not have been possible to implement this initiative without the support of senior managers Roby Yeo, Stacy Dowling, and Tania Laverty. We acknowledge Ashley Kehoe's hard work in supporting this program. Both Greg McQueen and Natasha Alliston were the two regular therapists and exceptionally committed to the program. Additionally, Greg McQueen provided project lead. Other therapists included Ashley Cox, Ryan Small, Chris Trimmer, Siobhan Andress and Richard Tyo. We thank Ashley Gerada and Alyssa Hirji in helping with the data input. We are most grateful to the IT department, AMHS-KFLA. Finally, we thank the clients who attended the program.

Correspondence concerning this article should be addressed to Farooq Naeem, 385 Princess Street, Kingston, ON, Canada K7L 2C7; (cell) 613-770-6890. Email: Farooqnaeem@yahoo.com

doi:10.7870/cjcmh-2017-008
Published by Canadian Periodical for Community Studies Inc.

**Mots clés :** faible intensité, thérapie cognitivo-comportementale, Improving Access to Psychological Therapies, thérapie cognitivo-comportementale de faible intensité.



There is a substantial need for cognitive behaviour therapy (CBT) for the treatment of mental health conditions in Canada. One possible solution might be to provide low-intensity CBT, such as those provided by Improving Access to Psychological Therapies (IAPT) in England, a community-based program that delivers CBT through a range of service providers after a relatively short period of training and supervision. An adaptation of IAPT may be a cost-effective way to bridge the gap in health care since it includes factors which contribute to well-being (such as symptom alleviation), functioning (such as workplace absenteeism), health care and other such costs.

## Need For a Low-Intensity CBT Program

Numerous mental health organizations, including the Canadian Psychological Association, have suggested an adaptation of IAPT as a cost-effective way to bridge the gap in health care as noted above (Dezetter & Vasiliadis, 2014). Popular media in Canada has also supported a solution based on the implementation of a low-intensity program in Canada like IAPT (Andersen, 2015). However, major hurdles to such a program seem to be a lack of local availability or capacity and limited resources**.**

The IAPT program was based on the assumption that "savings would offset the costs of initiating a low-intensity CBT Program in two main ways: reducing absenteeism from work and increasing returning to work" (Layard, Clark, Knapp, & Mayraz, 2007). Additional benefits include reduced use of healthcare resources and an increase in quality of life. The concept is underpinned by a stepped care approach to delivering psychological therapies so that an effective, yet least resource-intensive treatment, is delivered to service users first (Williams & Martinez, 2008).

We piloted an IAPT-like model in Kingston, Ontario. This article presents the first-year pilot outcome of this brief low-intensity CBT program, Cognitive Behaviour Therapy: Low InTEnsity (CBT Lite), delivered by frontline mental health providers in community settings.

## The CBT Lite Program

The intervention consisted of 6 to 10 sessions and was based on a CBT formulation. The salient features of the program included:

(a) provision of a flexible manualized CBT based on a formulation;

(b) delivery of the CBT Lite program to individuals with mild to moderate mental health problems delivered by frontline mental health providers;

(c) working within a stepped care model; and

(d) focusing on early intervention and prevention.

The purpose of this program was:

(a) adaptation of IAPT for local needs;

(b) creation of a workforce that will lead the change in the future in providing therapy to a range of service users; and

(c) developing a model of delivery of low-intensity CBT that can be replicated in other areas and be scaled for those with severe problems, such as psychosis, in the future.

Mental healthcare providers with behavioural science technology degrees, and who work as crisis, transitional case management or assertive outreach providers, were trained in 2-day workshops in the use of manual-supported CBT. (This manual can be obtained from Farooq Naeem.) Only those who had attended some CBT training in the past (range = 3 to 5 days training) were selected. The training focused on formulation, therapy plan, organization of sessions, homework, psychoeducation, anxiety management, exposure, cognitive restructuring, problem-solving, behavioural activation, sleep hygiene and education on food and lifestyle changes, and on communication, conflict management, and maintaining well-being. The providers then delivered therapy under supervision that was provided weekly by a trained CBT therapist for 60–90 minutes for the duration of the project.

Initial training included 12 frontline providers. Only two of the therapists continued to provide therapy for the duration of the project, each a half day per week, providing therapy to a total of 23 service users. The rest of the team members each delivered therapy to between 1–3 service users. This approach was designed to ensure capacity building, flexibility in the provision of treatment, and most importantly, sustainability of the program considering the poor resources available.

The program was organized by a program coordinator and program support assistant (PSA) who worked a half day per week each. All those referred to the program were assessed in two stages. During the first stage, referrals were screened by the program coordinator. The second stage consisted of selected service users being assessed by a member of the therapy team for the CBT Lite Program, who would continue with therapy if deemed suitable.

Inclusion criteria included those aged 18 or above with mild to moderate depression, or an anxiety related disorder who had not previously received the structured psychological intervention. Also, the service users must agree to work with a provider. Severity was assessed by high risk of suicide or self-neglect and no measurement scales were used for this purpose. Those with severe personality disorder, severe drug/alcohol dependence, psychotic disorder, severe developmental disability, or a high level of risk to self or others were not included. Informed consent was obtained to use the data for research evaluation purposes. We used the Revised CT Scale (Blackburn et al., 2001) as well as weekly supervision to address fidelity to the CBT model. The program received ethics approval from Queen's University.

Self-rating clinical measures were collected at every contact with the service users. The measures included the Hospital Anxiety and Depression Scale, Clinical Outcomes in Routine Evaluations, and WHO Disability Scale. A demographic data form was used to collect socio-economic and clinical information at the baseline. Providers recorded particulars of each session that were used to evaluate the program. This was also used to try to ensure adherence to the program and to assess fidelity to the treatment model. Statistical analyses were carried out using SPSS v22. A paired *t*-test was used to compare the baseline with the end-of-intervention scores.

**Lessons learned**

We offered CBT Lite to 53 service users who fulfilled the criteria; of those, 47 accepted the program. Participants demonstrated a variety of presenting complaints including mental health challenges, employment, relationship, legal, and social problems and difficulties in activities of daily living. Participants were mostly single ($N = 27$; 57.4%) females ($N = 27$; 57.5%) and employed ($N = 23$; 48.9%) with an average age of 32.5 years ($SD = 12.40$). We had low attrition (one participant dropped out of the program), and engagement rates were high with 13 participants attending 7 to 10 sessions and 24 participants attending between 3 to 6 sessions. There were significant improvements in measures of psychopathology (P = 0.000), anxiety (P = 0.000), depression (P = 0.000) and disability (P = 0.000). The effects of the CBT Lite program on the number of the days worked were encouraging. Total days per week worked by the group increased from 69 at the baseline to 169 at the end of the intervention.

Providers' feedback was overwhelmingly positive, with benefits such as professional and personal development, improved job satisfaction, and feeling as though they are better able to to help service users.

**Implications and the Way Forward**

Community mental health services provided support and delivery, low-intensity CBT to service users. The CBT Lite program showed improvement in clinical and work measures, and possibly net economic gains to the healthcare system.

This project may be difficult to replicate given the small sample size, high level of organizational commitment, and staff enthusiasm required. This pilot program, however, gives hope for the future; therefore, a larger-scale study with appropriate funding and organizational support of CBT Lite would be warranted. The results of this and future research may have considerable consequences for the dissemination of evidence-based psychological treatment to routine public practice.

## REFERENCES

Andersen, E. (2015, May 22). The case for publicly funded therapy. The Globe and Mail. Retrieved from http://www.theglobeandmail.com/life/the-case-for-publicly-funded-therapy/article24567332/

Blackburn, I., James, I., Milne, D., Baker, C., Standart, S., Garland, A., & Reichelt, F. (2001). The revised cognitive therapy scale (CTS-R): Psychometric properties. *Behavioural and Cognitive Psychotherapy, 29*(4), 431–446.

Dezetter, A., & Vasiliadis, H. (2014). The economic benefits of improved access to psychotherapy: Two studies. *Qualaxia, 6*(6), 1–2. Retrieved from http://www.qualaxia.org/mental-health-thematic-files/therapy-access/quintessence.php?lg=en

Layard, R., Clark, D., Knapp, M., & Mayraz, G. (2007). Cost-benefit analysis of psychological therapy. *National Institute Economic Review, 202*(1), 90–98.

Williams, C., & Martinez, R. (2008). Increasing access to CBT: Stepped care and CBT self-help models in practice. *Behavioural and Cognitive Psychotherapy, 36*(Special Issue 6), 675–683.