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A Clinician's Guide to Low Intensity Psychological Interventions (LIPIs) for Anxiety and Depression

by WA Primary Health Alliance

Peter McEvoy[1,2], Ebonnie Landwehr[1], Caitlin Pearcy[1], & Bruce Campbell[2]

Curtin University

Centre for Clinical Interventions

[1]School of Psychology, Curtin University
[2]Centre for Clinical Interventions, North Metropolitan Health Service

29th April 2020

McEvoy, P., Landwehr, E., Pearcy, C., & Campbell, B. (2021). A clinician's guide to low intensity psychological interventions (LIPIs) for anxiety and depression. Western Australian Primary Health Alliance.

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About this Manual

Low Intensity Psychological Interventions (LIPIs) can help to optimise a service's ability to match treatments to clients' needs, thereby efficiently and effectively providing the right care at the right time to the largest number of people. This manual provides clinicians with the information they need to implement LIPIs for adults with anxiety and depression.

Chapter 1 describes different types of LIPIs that services may wish to consider using with their clients, along with some guidance about how to match LIPIs to clients' needs. Chapter 2 presents more detail about completing a LIPI assessment and case formulation, along with a case formulation template and case examples for several clinical problems. Chapter 3 illustrates how clinicians can use their case formulations to implement targeted psychological tools and techniques within a LIPI. Case examples, a treatment planning template, and an example treatment plan are provided. Finally, Chapter 4 provides guidance on designing group LIPIs, which may be helpful when clinicians receive regular referrals for similar problems. A template for planning and designing a group LIPI is provided, along with case examples.

In conjunction with appropriate supervision, this manual should provide clinicians with a range of skills needed to plan and implement LIPIs from a cognitive behavioural framework.

This manual should be read in conjunction with the following documents:

PNH Primary Mental Health Care Flexible Funding Pool Programme Guidance: Low Intensity Mental Health Services for Early Intervention (2019).

PHN Primary Mental Health Care Flexible Funding Pool Programme Guidance: Stepped Care (2019).

PNH Primary Mental Health Care Flexible Funding Pool Programme Guidance: Consumer and Carer Engagement and Participation.

Clinician Support

For assistance with developing a LIPI for your service, contact Senior Clinical Psychologist and Research Director, Centre for Clinical Interventions, Curtin University, Professor Peter McEvoy
peter.mcevoy@curtin.edu.au

Disclaimer

The information set out in this document (the Manual) is current as at 29th April 2020 and is provided to assist people (Users) who provide low intensity psychological interventions to adults with anxiety and/or depression. The Manual is to be considered as an adjunct to a User's training, expertise and knowledge and is not to be taken as being exhaustive on the subject matter or being a replacement to appropriate training, skills, experience or clinical supervision or governance for Users delivering psychological interventions.

Users of the Manual must exercise their own independent skill and judgement or seek appropriate professional advice relevant to their own circumstances when doing so.

A User cannot, by following any guidance, recommendations, processes or templates contained within the Manual, assume that this will discharge the duty of care owed by them (and any organisation from which or for whom they work, as an employee or contractor) to any person to whom they assist or deliver low intensity psychological interventions to .

Whilst the Manual is directed to health professionals possessing appropriate qualifications and skills in ascertaining and discharging their professional (including legal) duties, it is not to be regarded as clinical advice and, in particular, is no substitute for a full examination and consideration of medical history in reaching a diagnosis and treatment based on accepted clinical practices.

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Chapter 1
An Introduction to Low Intensity Psychological Interventions (LIPIs)

Anxiety and depressive disorders are highly prevalent, with an estimated 3.6% (264 million) and 4.4% (322 million) of the global population experiencing these disorders, respectively (World Health Organization, 2017). Moreover, the prevalence of anxiety and depressive disorders increased by 14.9% and 18.4% between 2005 and 2015 (WHO, 2017). Depression and anxiety disorders also increase the risks for additional physical and mental health problems that adversely affect functioning and quality of life (Anderson, Freedland, Clouse, & Lustman, 2001; Barger & Sydeman, 2005; WHO, 2017). Despite these significant impacts, many people do not seek treatment due to a range of barriers to accessing effective, evidence-supported treatments. Evidence-supported Low Intensity Psychological Interventions (LIPIs) based on the principles of cognitive behavioural therapy (CBT) are designed to support people with mental health problems of mild to moderate severity. Importantly, LIPIs can help to address a range of barriers to treatment, including clinician shortage, long wait-lists, cost of services to the consumer, stigma, transportation issues, and the need for child care (Haarhoff & Williams, 2017; Renton et al., 2014; Shim, Mahaffey, Bleidistel, & Gonzalez, 2017).

Why Deliver LIPIs?

The primary aim of LIPIs is to increase community access to evidence-based treatments using the minimum amount of resources required to achieve optimal client outcomes. More intensive interventions should be offered to consumers with disorders of greater severity, so that interventions are matched to client needs. The features of LIPIs are described in Table 1.1 (Australian Government Department of Health; Bennett-Levy et al., 2010, p. 8-9).

Table 1.1 Features of Low Intensity Psychological Interventions (LIPIs)

Targeted	LIPIs are targeted to people with lower intensity mental health needs.
Time-limited	LIPIs are brief and structured interventions designed to provide an efficient and cost-effective alternative to more costly mental health services where these are not needed. The structured nature of LIPIs can facilitate treatment fidelity.
Evidence-based	LIPIs are evidence-based for the presenting clinical problems.
Highly accessible	LIPIs are designed to be easily and rapidly accessed by consumers when required, with or without a referral, although a general practitioner should be involved in health care. The frequency and volume of services should match consumers' needs.
Flexible	LIPIs are delivered in a variety of formats to best suit the client's needs and preferences, as well as health service resources.
Provided by a broad workforce	LIPIs are delivered by suitably qualified health professionals for the level of service being provided. LIPIs are not typically delivered by specialist mental health professionals, but are instead provided by generalist clinicians.
Regionally-focused	LIPIs are designed to address the needs of the area within which they are provided, particularly underserviced groups.
Recovery-focused	LIPIs are designed to promote recovery, and may provide links to other services to match consumers' needs.
Designed to promote coping	LIPIs are designed to help consumers to develop confidence in their own ability to manage their mental health more effectively, with support from health services as required. LIPIs often involve the use of psychoeducation, extensive self-help materials with limited clinician guidance, and between-session homework.
Effective	To ensure they are meeting the client's needs, LIPIs involve ongoing assessment of change in client-valued outcomes.

The Use of CBT in LIPIs

Cognitive behaviour therapy (CBT) is a structured, 'here and now' focused, and skills-based approach that has demonstrated efficacy (from research trials) and effectiveness (in real world treatment settings) for a large variety of clinical problems (Butler, Chapman, Forman, & Beck, 2006; David, Cristea, & Hofmann, 2018; Hofmann et al., 2012). CBT is an umbrella term describing a range of evidence-supported interventions designed to modify thoughts, behaviour, body sensations, and emotions. The CBT model can be used to formulate clinical problems and plan interventions. As such, the CBT model is a very powerful framework within which to design and apply LIPIs. There is evidence that low intensity CBT is also effective for anxiety and depression in various formats, including self-help psychoeducation, written and internet-based guided self-help, group CBT, and individual CBT (face-to-face, videoconferencing, telephone-based; Amos, Morris, Mansell, & Edge, 2018; Andrews et al., 2018).

The cognitive aspect of CBT involves the clinician helping the client to identify and modify unhelpful cognitions (e.g., thoughts, images) that are contributing to distressing emotions. Examples of cognitive techniques are thought challenging and behavioural experiments, which are designed to systematically evaluate and test unhelpful beliefs. Cognitive techniques also aim to shift clients' attentional focus from negative aspects of themselves and their experiences (past, present, and future) to more helpful, solution-focused, and proactive aspects of the 'here and now.' Clinicians help clients to reinterpret their experiences in a less black-and-white, overgeneralised, and personalised way, and to flexibly consider alternative, more helpful interpretations. The behavioural aspect of CBT is based on behavioural theories that self-defeating behaviours are learned and, therefore, can be modified. Examples of behavioural techniques are graded exposure for anxiety, activity scheduling as part of behavioural activation for depression, and relaxation to reduce physiological arousal.

Factors Influencing Service Intensity

Service intensity refers to the concentration of resources required to deliver an intervention from the clinician and health service perspectives, in addition to the cost-effectiveness of an intervention (Bennett-Levy, Richards, & Farrand, 2010; Bower & Gilbody, 2005). While the delivery of a LIPI may be lower intensity for the client in some respects (e.g., self-paced, brief, self-help completed at home), this does not translate to low engagement from the client. Indeed, some LIPI tasks, such as graded exposure to anxiety-provoking situations, will be very challenging for clients to implement. The intensity of an intervention therefore relates more to delivery, and not necessarily to the client's experience.

A range of factors can influence the intensity of a psychological intervention including the level of support, location, format, delivery, dose, who delivers the intervention, who receives the intervention, problem coverage, and cost. Table 1.2 provides examples of lower and higher intensity interventions for each of these factors.

Table 1.2 Features of Higher and Lower Intensity Interventions

	Lower Intensity	Higher Intensity
Level of support	Unguided (self-help)	Guided
Location	Home, community, non-government organisation	Primary care, outpatient, inpatient
Format	Group	Individual
Delivery	Internet/telephone	Face-to-face
Dose	Briefer	Longer
Who delivers	Generalist	Specialist
Who receives	Population	Individual
Problem coverage	Transdiagnostic approach	Specific to one diagnosis
Cost	Less per client	More per client

Level of Support

Level of support refers to whether an intervention is unguided (e.g., self-help) or guided by a clinician. Evidence suggests that guided CBT has better treatment outcomes, response rates, and adherence compared to unguided interventions (Domhardt, GeBlein, von Rezori, & Baumeister, 2019). An example of an unguided intervention is bibliotherapy, in which the client is given books or online psychoeducation material to read on their own. By contrast, a guided intervention involves limited contact with a clinician to support the process of applying the treatment principles. Clinician guidance for LIPIs can occur via telephone, email, or online, as well as via face-to-face group or individual sessions. Although unguided CBT has the disadvantages of higher drop-out rates and poorer treatment outcomes, it provides access for clients who may have no opportunity to engage in guided or face-to-face support.

Location

The client's location when receiving an intervention can also have an impact on its intensity. Lower intensity interventions are accessible at home (e.g., self-help, telephone support, internet-based), within their community (e.g., support groups), or through non-government organisations. Higher intensity interventions may be provided through either outpatient or inpatient hospital settings or Primary Health Networks.

Format and Delivery

The format in which therapy is provided can affect intensity with respect to a clinician's time. For instance, group therapy with 6 to 8 clients per clinician will require fewer clinician hours per client than individual therapy. The delivery format of individual therapy will also affect the intensity of an intervention (e.g., face to face, videoconferencing, or telephone). It is important here to consider the needs of particular clients and populations with respect to the complexity and intensity of symptoms, location, access, and availability of services. For example, some face-to-face services may not be available in rural locations, or waitlists may restrict access to immediate intervention. In these instances, lower intensity services may maximise access and optimise outcomes.

Dose

LIPIs are cost-effective, structured, and relatively brief interventions with respect to number, frequency, pace, and length of sessions. In a review of predictors that enhance recovery rates in LIPIs, Gyani, Shafran, Layard, and Clark (2013) found that clients treated with more sessions were more likely to recover. Unfortunately, access to a high number of sessions is not always possible. As such, alternatives like single session therapy, psychoeducation classes, and self-help resources may benefit some clients who have been assessed as having a problem that can be appropriately treated with a LIPI.

Who Delivers the LIPIs

Specialist mental health professionals are relatively scarce, and this impacts the availability of mental health services. Many PHNs use the NewAccess training by the CBT Institute and Flinders University as the benchmark for LIPIs. Basic training in CBT is usually sufficient for a variety of health professionals to deliver effective LIPIs, in conjunction with appropriate supervision and oversight from more experienced and specialist CBT clinicians, as long as the following competencies are met (Bennett-Levy et al., 2010; Hughes, Herron, & Younge, 2014):

- Understand the rationale and foundation for CBT
- Capacity to conduct a CBT assessment
- Knowledge of the clinical problem and basic CBT skills
- Problem identification and problem-solving
- Develop hypotheses about how problems may be maintained
- Incorporate goal setting
- Understand the importance of structuring sessions
- Monitor progress using measures and self-report records
- Ability to develop a strong therapeutic alliance

Access to mental health services can be increased when LIPIs are provided by clinicians from a variety of professional backgrounds (e.g., mental health nurses, social workers, provisionally registered psychologists, GPs, peer support workers). Clinicians with specialist training can devote more time to delivering more intensive interventions for higher need clients.

Who Receives LIPIs

Optimal outcomes will be achieved when the intensity of a service matches the client's needs. Over-servicing is inefficient and directs resources away from people who need them most. Under-servicing can result in sub-optimal care and outcomes. The complexity of a client's presentation impacts the intensity or 'step' of care required, and ultimately this requires clinical judgement and can be informed by psychometric measures (see Chapter 2). LIPIs generally aim to provide more generalised treatment to a population with less complex mental health difficulties. Short-term, standardised, and structured LIPIs can be highly effective for many people with mild to moderate mental health problems.

Problem Coverage

LIPIs aim to teach clients specific strategies that can be applied to multiple clinical problems. For instance, cognitive restructuring (challenging negative thoughts) can be applied to fearful and depressing thoughts. This transdiagnostic approach can simultaneously treat comorbid mental health difficulties (e.g., depression and anxiety), which can be more effective and efficient than treating individual problems sequentially. Higher intensity psychological interventions may be tailored to a specific, chronic, or complex mental health diagnosis experienced by an individual client (e.g., treatment of posttraumatic stress disorder).

Cost

Higher intensity psychological interventions are more resource intensive and use high-cost and restricted specialist services. LIPIs aim to be highly accessible while also being briefer and less resource intensive. LIPIs are therefore generally less costly to deliver than high intensity services.

Stepped Care

CBT has a strong evidence-base for mild to moderate mental health problems, but access is limited due to long waitlists, the cost and time associated with training clinicians, or physical and geographical constraints. As a consequence, a large number of people who could benefit from treatment do not receive it. Stepped care is a person-centred approach that matches services to clients' needs, and can increase access to evidence-based psychological treatments by allocating limited resources more effectively and efficiently. There are models under which individuals start with the least restrictive and resource-intensive treatment (e.g., lowest intensity treatment), and progressively move up to more intensive interventions if they do not sufficiently benefit from earlier steps. While this might be appropriate for some clients, the risk of this type of approach is that others will receive an insufficient 'dose' of treatment to benefit. Delayed access to a higher intensity treatment may lead to prolonged or increased distress, disability, and hopelessness about the benefits of treatment. If an individual with high care needs progresses through several forms of care before receiving the most appropriate treatment, this will also reduce the cost-effectiveness of the treatment. In contrast, models that aim to match care provide the intensity of treatment required by each client in the first instance. If a client requires a high intensity treatment then they receive it, potentially stepping down to a lower intensity treatment once symptoms abate. A LIPI should be offered if a client does not require a higher level of care. The aim is to provide the lowest, least restrictive level of care for the client to achieve significant improvements to their health. See the ***Primary Health Network's guidance document*** for more information on the stepped care approach.

Implementing Stepped Care for LIPIs

An initial assessment needs to be undertaken to identify the appropriate step to match the client's needs (see Chapter 2 for further information on assessment). Health service managers and clinicians will need to consider which modalities of LIPIs are feasible within their setting. Table 1.3 below describes the advantages and disadvantages of different treatment modalities of LIPIs, as well as questions to guide clinicians to an appropriate LIPI for a particular client and service. Please note here that we are referring to LIPI's only, which are recommended for mild to moderate mental health issues. Higher intensity interventions may be warranted if symptoms escalate, or if more complex psychological difficulties are identified. Considerations when implementing stepped care include:

Service perspective

- What low intensity services (e.g., online) are available for the clinical problem?
- Is there access to particular LIPIs (e.g., online services)?
- What resources are available within the workplace?
- Can the service ensure treatment fidelity for face-to-face treatments?
- Are there multiple clients with similar presentations who could benefit from group LIPIs?
- Are there waitlists for individual services?

Client perspective

- Does the client have a preference for treatment format?
- Is the client willing to use online services?
- Is the client willing to use online services as a supplement to face-to-face treatment?
- Does the client feel competent in their computer literacy skills?
- Does the client have any visual, hearing, or reading difficulties that may prevent effective use of materials?
- Is English the client's first (main) language?
- How motivated is the client to engage in LIPIs?
- Is the client feeling ambivalent about therapy?
- Does the client have a physical disability or mental health issue (e.g., agoraphobia) that makes it difficult to leave the house?
- Are there any other obstacles that might make attending a clinic difficult (e.g., family commitments/ childcare arrangements, transportation issues, geographical location)?

Table 1.3 Advantages and Disadvantages of LIPI Modalities

ONLINE / WRITTEN SELF-HELP	
Advantages	**Disadvantages**
• High accessibility • No clinician required • Fidelity • Own time and pace • Low cost • Materials always available for reference • Convenience – no need to schedule appointments • Anonymity, eliminates social stigma	• Requires internet access if online • May experience technological issues • Client needs to be confident with the internet if online • Limited therapeutic relationship • Requires a high level of commitment and self-motivation/drive from the client • Level of literacy required
TELEPHONE-BASED: INDIVIDUAL	
Advantages	**Disadvantages**
• Anonymity due to absence of face-to-face contact • High accessibility	• Absence of nonverbal cues • Possible lack of privacy on client's end (client required to manage) • Client may experience less trust and commitment when not face-to-face
VIDEOCONFERENCING: INDIVIDUAL	
Advantages	**Disadvantages**
• High accessibility • Face-to-face may facilitate stronger therapeutic alliance	• May experience technological issues • Nonverbal cues may be more difficult to pick up on videoconferencing • No anonymity
FACE-TO-FACE: INDIVIDUAL	
Advantages	**Disadvantages**
• Client may prefer face-to-face • Clinician can monitor client engagement • and progress • Clinician able to use micro skills based on verbal and nonverbal cues	• More expensive than other formats • Requires client to attend clinic • Only available during office hours
GROUP THERAPY	
Advantages	**Disadvantages**
• Clients may prefer face-to-face • Assists in normalising difficulties • Clinician can monitor client engagement and progress • Group support can be therapeutic • Opportunities for role playing • Learning from other group members' experiences	• Limited flexibility on session times • Requires client to attend clinic • Only available during office hours • Reduced anonymity

Who Are LIPI Services Appropriate For?

Client Symptom Severity

LIPI services are generally appropriate for the treatment of milder mental health problems, however, special consideration is needed to determine the client's ability to make use of specific cognitive behavioural techniques. Symptom severity can be determined through clinical assessment and psychometric measures (see Appendix A for example measures that are freely available). LIPIs are not recommended for moderate to severe mental health problems, but if higher intensity services are not immediately available, a lower intensity intervention may be offered in the first instance. In general, the greater the severity, complexity, and intensity of symptoms, the more support and higher intensity services are required.

Targeted to Specific Clinical Problems

LIPIs are typically designed to teach strategies that will help clients manage specific clinical problems. The strategies may be generalisable to multiple clinical problems, and may therefore be considered transdiagnostic. LIPIs may be provided in some instances to help the client manage a circumscribed aspect of more complex problems. For example, a client with personality pathology that is associated with elevated anxiety may benefit from learning de-arousal and basic cognitive restructuring skills. The clinician may be aware that this intervention will not address all of the client's problems, but a LIPI may help them better manage their distress until higher intensity services are available.

High Prevalence Conditions

The evidence base for LIPIs is strongest for high prevalence disorders such as depression and most anxiety and anxiety-related disorders (e.g., generalised anxiety disorder, social phobia, obsessive compulsive disorder, specific phobia, and panic disorder) (Dalton, Read, Handley, & Perkins, 2017). There is some evidence supporting the use of LIPIs in the treatment of eating disorders until higher intensity services can be accessed, however, further research is required (Fursland, Erceg-Hurn, Byrne, & McEvoy, 2018). LIPIs are not recommended for the treatment of PTSD, which requires higher intensity face-to-face, trauma-focused psychological therapy (NICE, 2018). Furthermore, suicide risk needs to be carefully considered, as well as symptoms of mania and psychosis, which require higher intensity services. Although LIPIs may not be useful for targeting all clinical disorders, psychoeducation is likely to be helpful while waiting for specialist services.

Additional Considerations

A number of additional considerations need to be taken into account when determining who LIPI services are appropriate for. Clients may not be able to access face-to-face treatments for a range of reasons (e.g., live in rural and remote areas, work commitments during office hours, mobility issues), so online or guided self-help might be the only options. In these instances, clinicians should consider what online services clients may be able to access (e.g., see ***Headtohealth.gov.au*** for a range of digital mental health resources; ***Centre for Clinical Interventions*** for self-help materials; ***Mindspot.org.au*** for online assessment and treatment; ***PORTS*** for clients who meet criteria for referral). In addition, stigma might be a significant barrier to help-seeking for some clients, in which case telephone, online, or self-help might be preferred.

Clinicians will also need to consider client motivation for engaging in treatment, and their capacity to benefit from LIPIs. Clients with low motivation may benefit only from psychoeducation about their clinical problem and information about the available services if and when they are ready to engage with them. Clients with limited cognitive capacity might need materials to be simplified (if modified materials are not already available), and may require more clinician guidance. Clients who are impacted by substance use disorders or brain injuries are also less likely to benefit from self-guided LIPIs.

Summary

LIPIs offer an important opportunity to provide evidence-based treatments to people with mild to moderate symptoms of mental problems while overcoming barriers such as limited service resources and specialist skills, stigma, and inaccessibility of face-to-face mental health services. LIPIs can be cost-effective and successfully reduce client's symptoms while ensuring the right level of care is matched to the client's needs at the right time.

Chapter 2
LIPI Assessment and Problem Formulation

A LIPI assessment is brief and provides enough information for the clinician to determine if the client's problem is appropriate for a low intensity intervention. The clinician needs to quickly establish a therapeutic alliance and prepare the client to be actively engaged in the treatment. This chapter will provide an overview of a LIPI assessment, along with information on how to complete a risk assessment, use measures to assess outcomes, and develop a problem statement and case formulation.

Essential Considerations

Appropriate Problems for LIPIs

LIPIs are suitable for mild to moderate mental health problems with limited complexity (e.g., no active suicidal intent). Clients with complex presentations may still benefit from a LIPI, but the clinician and client need to be clear about the specific problem that is being treated (e.g., using relaxation to reduce anxious arousal rather than treating a psychotic illness). LIPIs can address discrete common psychological problems such as depression, anxiety, panic, and phobias (Papworth, Marrinan, Martin, Keegan, & Chaddock, 2013), as well as sleep issues and stress. The clinician needs to make a judgement about whether the client could benefit from learning specific cognitive behavioural techniques, such as psychoeducation, structured problem-solving, cognitive restructuring, behavioural activation, and behavioural experiments. Chapter 3 provides information about these strategies.

Active Participation

As described in Chapter 1, low intensity interventions from the clinician's perspective (e.g., briefer) are not necessarily lower intensity from the client's perspective. While the clinician's role may be to provide support and guidance, clients need to take primary responsibility for implementing their LIPI. For optimal outcomes, the client needs to be actively engaged within sessions and to regularly apply the treatment principles between sessions.

Building Rapport

Building rapport with the client is important in any therapeutic relationship, and this needs to be established rapidly during the initial assessment within the context of a LIPI. Reflective listening skills (e.g., paraphrasing and summarising) can help to demonstrate that the clinician is attuned to the client, empathetic (understanding the problem from the client's perspective), and non-judgmental (Papworth et al., 2013). It is important to remember that assessment can cause anxiety or discomfort for clients. The client is being asked to discuss difficult or deeply personal information with someone they may not yet trust (Williams and Chellingsworth, 2010). Disclosure can be a difficult experience and clients may present for assessment in a number of ways. For example, one client may exhibit low motivation if they are feeling hopeless, while

another shows high levels of frustration if they have engaged in an assessment process and answered similar questions in the past. Being sensitive to the client's concerns and showing understanding for how they are feeling can aid in building a good relationship (Williams and Chellingsworth, 2010). Rapport can be established with the client when time is limited by:

- Providing the client information about the clinician and service ahead of the assessment
- Displaying warmth, genuineness, accurate empathy, eye contact, and interest in the client
- Paraphrasing
- Working collaboratively, taking a client-centred approach
- Asking the client to complete self-rated measures or workbooks before the session or as homework, rather than during the assessment

The assessment session benefits both the clinician and the client (Williams & Chellingsworth, 2010). The assessment allows the clinician to learn about the difficulties the client is experiencing, how these problems are affecting the client's daily life, and to subsequently identify targets for change (Bennett-Levy et al., 2010; Williams & Chellingsworth, 2010). The assessment session also allows the clinician to evaluate the client's risk, motivation towards treatment, current medication use, and any history of drug and/or alcohol use or misuse (Bennett-Levy et al., 2010). For the client, it may also be the first opportunity they have had to understand the problems they are experiencing and to gain some insight into why they are feeling the way they do (Williams & Chellingsworth, 2010). Psychological treatment is unlikely to be successful unless the client feels confident that they can discuss their problems in a safe, trustworthy space. An assessment should not feel like an interrogation to the client. Rather, it is a means to better understand the client and their life difficulties (Hughes, Herron, & Younge, 2014). Rapport is enhanced by ensuring the assessment is client-focused and instils a sense of hope that change is possible.

To start developing rapport, the clinician would usually start with a general introduction, a description of their qualifications, and to ask the client's preferred name. It is also important to explain to the client the purpose of the assessment, how long they can expect it to take, and how the session will be structured (Bennett-Levy et al., 2010). The clinician should attempt to create an environment in which the client feels they are informed and that they have control over their treatment (Williams & Chellingsworth, 2010). At this stage, informed consent and the limits of confidentiality should also be discussed, before the client starts sharing their problem(s). The client may assume that anything they discuss in the context of therapy is confidential, so it is important to have this conversation early, and ensure that the client understands when and why confidentiality would be broken. The service's routine correspondence with the primary health clinician and referrers should also be discussed.

Working Over the Telephone

Research indicates that counselling delivered over the telephone can be as equally effective as counselling delivered face-to-face (Bee et al., 2008). However, this mode does come with some challenges that need to be considered and managed. Lovell (2010) provides a number of strategies to address these challenges. Firstly, the therapeutic relationship can be enhanced by providing the client with some information about their clinician in advance of their first session. Information might include the clinician's name, their role within the service, their background and qualifications, and even a photograph. This allows the client to build a picture of who they are speaking with over the telephone. It is also a good idea to discuss with the client in advance of the first treatment session, that working over the telephone can involve long silences, and that these pauses represent the clinician taking notes or thinking about what has been said. It does not mean the clinician is no longer listening. Other things to consider are ensuring the client has an appropriate space in which to take the telephone call, where they will be uninterrupted and have a level of privacy. In the therapy phase, the client should also have all session materials to hand prior to the session starting. Discussing a code word in advance that the client can use to indicate they need to end their session prematurely is also advised. This may occur when the client unexpectedly receives company. Ensuring these issues have been considered prior to commencing treatment can aid in making the telephone modality work smoothly.

Working with Video-Conferencing

Services that are considering incorporating video-conferencing into their service will need to decide on a platform that is sufficiently secure and reliable (e.g., end-to-end encryption, location of stored session recordings). Professional associations publish guidelines for practitioners that can help with these decisions. Practice managers, clinicians, and administrative staff will need to agree on the scope of telehealth services that will be provided, exclusion criteria, and who they can contact in case of technical problems.

The technology will need to be set up on the clinician's and client's computers ahead of the sessions (with instructions provided to clients), and the client will need to receive a secure, password-protected link to the telehealth session. Questionnaires required for assessment will need to be administered online, via email, or posted ahead of the session. Likewise, any handouts and worksheets that you plan to work with during the session should be made available to the client before the session. Contingency plans for when technology fails should also be in place (e.g., clinician will call the client). Extra time should be allocated to the first consultation in case of technical problems, particularly for clients without video-conferencing experience. Given the potential for information to be missed due to technical problems, it is important that the clinician regularly summarises key points of the discussion to prevent misunderstandings. The clinician should ask the client if they need anything clarified, and if they are comfortable to use video-conferencing again, before scheduling the next session. The Australian Psychological Society has published guidance for practitioners about ***choosing videoconferencing technology*** and ***considerations for providers***.

Explain the Purpose and Structure of LIPI

The remainder of this manual is most relevant to LIPIs that involve some level of verbal or face-to-face interaction between the clinician and client, although many of the general principles will also be applicable to online LIPIs without clinician guidance.

A good assessment requires the clinician to:

- Establish rapport and a therapeutic relationship with the client
- Accurately identify the presenting problem(s)
- Determine the service's suitability for the client
- Identify an appropriate outcome measure
- Collect baseline measures that can inform the treatment plan
- Collaboratively decide with the client on an evidence-supported treatment plan

When a client first attends for assessment, it may be their first contact with a mental health service (Chellingsworth, Kishita, & Laidlaw, 2016). They may be relying on media representations of therapy or the experiences of their family or friends to understand the process ahead of them. Providing a clear outline of what the LIPI will involve gives the client a more realistic sense of what their treatment will entail and how active they will need to be throughout. From the outset, clear information about the purpose and structure of a LIPI should be provided to the client (Chellingsworth et al., 2016). The client needs to understand that the approach is time-limited and their collaboration and active participation is required at all stages. This includes formulating and prioritising their problem(s), deciding on a treatment approach, and completing homework tasks between sessions. For example, the clinician might start by saying:

"*Today's session will last for around 30 minutes. We will start with you telling me a bit about the difficulties you've been experiencing, and what your goals are in coming in for treatment. After that, we will work together to come to an understanding of what treatment could work best for you, and discuss the next steps.*"

Once the assessment is complete, if the clinician believes that the client could benefit from a LIPI, they might say:

"*What I've heard today is that your main problem(s) is(are) [insert a brief description of the main problem(s)]. I think it could be helpful for us to meet for an initial three sessions and work on some strategies to help you manage these issues. Specifically, I think some structured problem-solving and behavioural activation could be helpful skills for you to apply to these problems. How would you feel about learning some new ways to think through problems and generate potential solutions, and also some ways to increase your social supports and start doing some things that will give you more of a sense of pleasure and achievement in your life?*"

If the client agrees that this would be helpful, the clinician might say:

"*That's great to hear. What I'm suggesting is that we meet and talk through these strategies, which my past clients have found helpful for these sorts of problems. I will give you some written information and worksheets that can help guide you through the process. It will then be really important for you to try the strategies as often as you can between sessions, and come back and let me know how they worked for you. How does that sound?*"

Adapting to Time Limits

LIPI assessments are time-limited and typically last around 30-40 minutes. This means that assessment needs to be focused and may not involve an overly detailed history. Depending on the treatment setting, assessment procedures can be adapted to different formats, including face-to-face, telephone, or online (Bennett-Levy et al., 2010). Some settings may have very little time (e.g., 10 minutes) available to conduct an assessment. In this situation, the clinician may not have time to assess the client's history, and instead the focus should be on identifying the key current problem areas for the client and introducing the relationships between thoughts, behaviours, emotions, and body sensations. An initial simple working formulation (see the Hot Cross Bun Model later in this chapter) can be developed with the client and then updated at subsequent appointments if required. The client should be provided with a copy of the formulation to take home with them. To maximise the time available during assessments, clients can be asked to complete workbooks, self-assessments, or online measures prior to their appointment (Williams & Chellingsworth, 2010).

More time can be dedicated to understanding the factors that improve or worsen the problem the client is experiencing if more time is available (e.g., 30 minutes). More attention is also given to helping the client understand how their thoughts, behaviours, emotions, and body sensations interact as part of a vicious cycle. The clinician should use as many of the client's own examples as possible while describing the links between these components of the formulation. Some time can be spent summarising and checking the conceptualisation of the problem, and collaboratively identifying the target(s) for change. A full CBT formulation can be developed in settings where an hour is available for assessment (Williams & Chellingsworth, 2010).

Outcome Measures

Outcome measures can help assess a client's symptoms and wellbeing in a systematic way (Child Outcomes Research Consortium, CORC, 2019). Benefits of administering clinical measures as a routine part of LIPIs include:

- The client's distress may be normalised purely by virtue of the fact that a measure of their particular problem exists (Papworth et al, 2013).
- The information can help guide the collaborative case formulation. Most measures will assess body sensations, thoughts, emotions, and behavioural symptoms, which can be placed within the client's formulation so that it reflects their experience.
- The measures can quantify the severity of the client's distress, which is important for making sure they are receiving the appropriate level of clinical care. For example, if a client reports anxiety and depression, measures of both symptoms can inform the clinician about which symptoms are more severe. The clinician might then decide to treat the most severe problem first. Alternatively, if the client's problem is assessed as being in the severe range, a higher intensity treatment might be more appropriate.
- Scores can be graphed and compared at each session to evaluate whether the treatment is effective (e.g., symptoms are reducing and wellbeing is improving over time). If the client is not benefiting from treatment, the clinician can quickly respond to this information by modifying the formulation (checking that nothing important is missing) and/or the treatment plan. If the client is benefiting from treatment and symptoms are improving, then this is helpful feedback for both the client and clinician.
- More broadly, outcome measures ensure accountability and contribute to enhanced quality, efficiency, and cost-effectiveness of services over time (UCL, 2019), which has a direct benefit for clients and clinicians.

Clients should be asked to complete a minimal number of short clinical measures to support their assessment and ongoing treatment. Outcome measures should not be time-consuming for the client to complete and the client needs to understand why they are being asked to complete them. Research indicates that clients generally find outcome measures beneficial and that their use can improve the therapeutic relationship (Unsworth, Cowie, & Green, 2012). The outcome measures the client is asked to complete should be chosen carefully (Bennett-Levy et al., 2010), and will depend on the treatment setting and the nature of the client's difficulties. Mood, anxiety, and wellbeing are commonly assessed. Other areas that may be relevant to assess are insight, health, employment, education, lifestyle, and level of coping (Papworth et al., 2013).

These measures are not diagnostic tools, but when used with clinical judgement they can inform treatment. It is important to be mindful of anything that might invalidate the results of psychometric tests, such as vision

impairments and literacy problems (Papworth et al., 2013). CORC (2019) provide a number of key factors to consider when selecting a measure:

Purpose	What do you want to know more about or need to understand better?
Validity	Has research demonstrated that the tool measures what it says it does?
Reliability	Has research demonstrated that the tool performs consistently?
Target Population	Is the tool designed for use with your population?
Cost	Is the tool inexpensive (preferably free to use)?
Efficiency	Is the tool easy to score and interpret? Does it take a long time to complete?
Accessibility	Is the tool already used in your organisation or work setting?
Perspective	Do you want to know more about the client's or another person's perspective (e.g., parent)?

Appendix A provides information about a number of outcome measures in the public domain for a variety of psychological problems. For PHN commissioned mental health treatment programs, it is mandatory to administer the K10 at service entry and exit.

Risk Assessment

Risk assessment should form a standard component of LIPIs, at assessment and subsequent treatment sessions (Bennett-Levy et al., 2010). Suicidality is not exclusive to severe psychiatric presentations and may be present in mild to moderate psychological problems (Papworth et al., 2013). Exploring suicidality with the client will not increase their risk; rather, it may reduce the client's risk by providing them a safe outlet to discuss their current difficulties (Hughes, Herron, & Younge, 2014). Hopelessness and loss are common precipitants to suicide (Papworth et al, 2013). Look out for indicators of relationship loss (e.g., divorce, conflict, breakdown), bereavement, job loss, and deterioration of health, and if identified, explore these with the client. Substance use and suicide within the client's social network also increase risk. Of course, these are not the only factors to be aware of and clinical judgment plays a key role in identifying risk. If there are concerns about a client and their risk, the service's risk management protocols should be followed, and support and advice sought from a supervisor or a senior clinician (Hughes, Herron, & Younge, 2014).

There are five key areas to consider when rating a client's suicide risk (Bennett-Levy et al., 2010):

Intent:	Ask the client if they currently or have ever had thoughts about suicide, and if so, assess the content and frequency of the thoughts.
Plans:	Ask the client if they currently or have ever made a clear plan for suicide, and if so, assess the nature of the plan.
Actions:	Ask the client if they have ever attempted suicide or self-harm, or if they currently engage in actions intended to complete suicide or self-harm. Consider their access to means (e.g., weapons, hoarding medications), ask what actions they have taken, and how close they are to completion.
Prevention:	Ask the client about things in their life that are preventing them from completing suicide. For example, does the client have children, strong support networks, religious beliefs, or other factors of a protective nature?
Risk of harm:	Ask the client if they believe they are at risk of harming themselves or another person, whether intentionally or unintentionally. For example, harm might be due to neglect, or it could be intentionally directed violence.

If the risk assessment indicates there is a risk of harm to self or others, then this will be the focus of the session.

Problem Statements

As a general rule, there is not enough time available in LIPIs to conduct a complete developmental and family history background. The clinician should however try to understand how the client functioned prior to experiencing their current problem(s) and ask the client what they would like to achieve during treatment (Hughes, Herron, & Younge, 2014; NHS, 2019). A problem statement is a short description of the

client's presenting symptoms (thoughts, emotions, body sensations, and behaviours) and triggers of these symptoms (Chellingsworth et al., 2016). It should also succinctly identify the impact these symptoms are having on the client's daily functioning. Problem statements are generated by the client with the help of the clinician, and they generally should be written in the client's own words. Goals and treatment targets should be described in the statement (Chellingsworth et al., 2016). An example problem statement is:

"*My husband got an interstate transfer for his work. We moved here 6 months ago, and I have not been able to find a job. I also don't know anyone here. I always feel really tired, which makes it hard to get motivated to apply for jobs or try to meet people. Because I am isolated, I feel sad and depressed.*"

The client should be given the opportunity to clarify the statement and ensure it is a clear representation of the distress they are experiencing. Such a problem statement can help the clinician to keep sessions focused and avoid ineffective use of session time. This statement can also be used to measure progress throughout treatment, as it provides a baseline of the client's experience when they first attended for assessment, prior to any intervention (Papworth et al., 2013). Creating a problem statement often includes a number of areas that are not going well for the client, which may be overwhelming. It is important to normalise their experience and interact with the client in an empathetic and non-judgmental manner (Papworth et al., 2013).

Simple LIPI Case Formulation

Central to the effectiveness of LIPI is the delivery of treatment that targets active symptoms. The CBT model is concerned with the 'here and now', focusing on the problems that are currently affecting the client's life (Bennett-Levy et al., 2010). One way of making informed clinical decisions regarding what treatment is provided to the client is to create a collaborative case formulation. Because LIPIs are time-limited and rely heavily on clients taking an active role in their treatment, opportunities to reformulate the client's difficulties at a later time may not be available to the clinician. This means it is important to get a clear and accurate understanding of the client's problem(s) from the outset (Papworth et al., 2013).

The aim of formulation is to collaboratively identify and summarise the client's problems. This can then be used to guide an appropriate treatment plan (UCL, 2019). To inform the formulation, the clinician needs to gather information relating to the problem(s) the client is currently experiencing - how the problem affects their life, what strategies the client does use or has used to manage the problem (both helpful and unhelpful), how the client perceives and judges themselves, as well as a past psychiatric history (NHS, 2019; Williams & Chellingsworth, 2010). Formulation has a number of advantages, including:

- Guiding the client through a process of linking their thoughts, emotions, behaviours, body sensations, and triggers, resulting in a greater understanding of the problem, how it started, and the factors that maintain it
- Providing the client and clinician with clear treatment priorities and a rationale for the chosen treatment
- Generating a sense of hope in the client that they can feel better, ultimately increasing motivation to engage in treatment.

The role of the clinician is to build on the information the client presents when describing their situation, to enhance insight and understanding. Formulation should be a personalised attempt to understand the problem in the context of why and how it occurs for this individual client. Simplifying the problem(s) into a visual model is often helpful for illustrating the client's symptoms, how they interact, and how treatment can help to interrupt the maintenance cycles.

The client's input and feedback should be sought throughout the process of assessment and formulation. The clinician must ensure that they have understood the client and are able to summarise their current difficulties accurately, as this will have a direct impact on treatment selection and success. Once enough information has been gathered to create a formulation of the client's problem, the clinician and the client need to agree on what is not currently working well for the client. From here, the clinician can introduce the idea of change, and a collaborative decision can be made on what to target in subsequent treatment sessions (Hughes, Herron, & Younge, 2014).

Hot Cross Bun Model

One simple way to develop a case formulation, sometimes referred to as the 'Hot Cross Bun' model (Padesky & Mooney, 1990), illustrates how multiple factors work together to maintain distress. The factors include the client's:

- Trigger (situation / context / environment)
- Cognitions (thoughts / assumptions / beliefs / mental Images)
- Emotions
- Behaviours
- Physiological reactions (body sensations)

See Appendix C for a template of the Hot Cross Bun model.

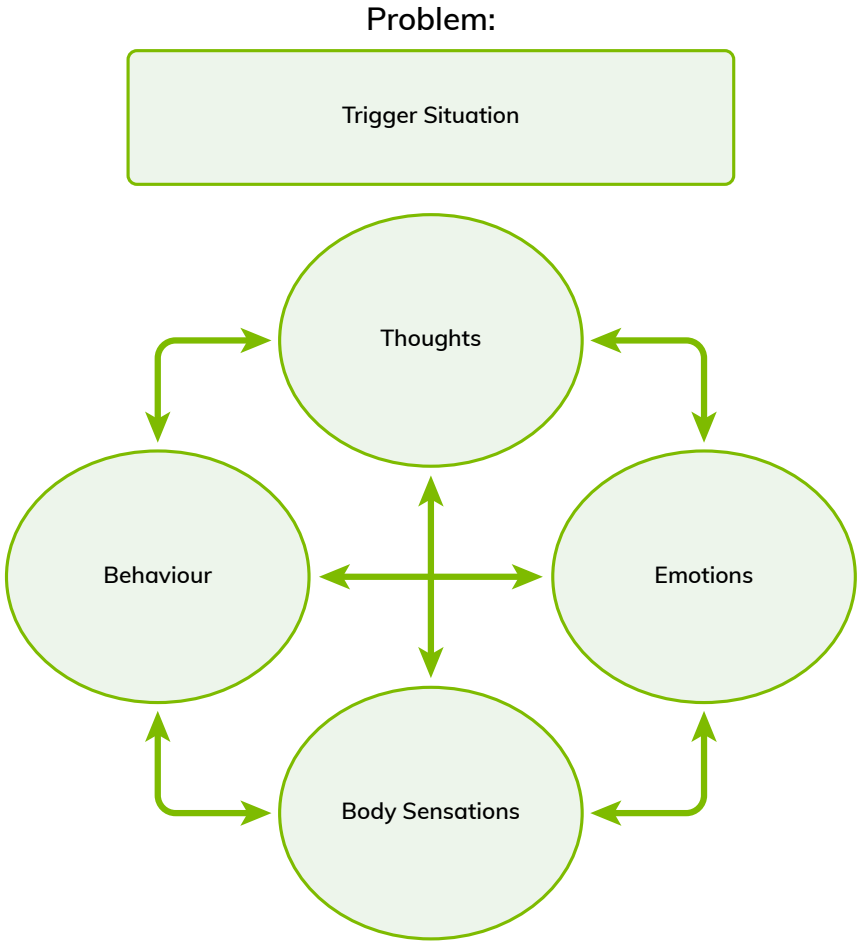

Figure 2.1 Basic CBT Hot Cross Bun Model

The trigger for the client's problem can be an external situation or internal cue. For example, noticing an uncomfortable physical sensation, such as a rapid heart rate, would be an internal trigger for someone who experiences panic attacks (Hughes, Herron, & Younge, 2014). Emotions refer to the feelings the client experiences in relation to their distress (e.g., sad, anxious, angry), and they are often the easiest component of the model for the client to identify and describe. Cognitions include thoughts (including intrusive thoughts), beliefs, and assumptions, as well as mental images.

Clients will often find it much easier to discuss their difficulties in terms of how they feel emotionally (e.g., sad, depressed, anxious) compared to identifying their thoughts (Hughes, Herron, & Younge, 2014). It is important to note that clients might describe thoughts as feelings. For example, if the client says "I felt like I was going to die", you can help them disentangle the thought "I am going to die" and the feeling associated with this thought (e.g., terror). Distinguishing thoughts from feelings is important and this helps clients to understand how their interpretations (thoughts) lead to their feelings.

Body sensations refer to physical symptoms the client experiences when they are depressed or anxious. Examples include physical heaviness or fatigue when depressed or increased heart rate, shaking, and sweating when anxious.

The behaviour component of the formulation refers to what the client does in response to these sensations, thoughts and emotions; for example, disengaging from social activities or hobbies, avoiding paying bills, or calling in sick to work. Behaviours are generally within the direct control of the client and therefore are a good target for treatment (Papworth et al., 2013). It is important to take the time to identify clients' safety behaviours, as they may not be aware that their reactions and responses to their distress are linked to their anxiety (Hughes, Herron, & Younge, 2014). Gaining a detailed insight into these behaviours will not only help the client to conceptualise how their reactions maintain their distress, but will also help to prevent these behaviours interfering with treatment at a later time. Clients often find it particularly helpful to understand how each component interacts to maintain the presenting problems (e.g., so called "vicious cycles") whereby thoughts lead to emotions and body sensations, which in turn lead to behaviours, ultimately strengthening beliefs and thoughts.

During the assessment, the clinician might find it helpful to complete the Hot Cross Bun Case Formulation Model (Handout 2.1 – Appendix C) and the Individual LIPI Formulation and Treatment Plan (Handout 2.2 – Appendix D). A Quick Guide to LIPI Assessment (Handout 2.3 – Appendix E) has also been included.

Example Interview Structure

Introduce Session (5 minutes)

To start the assessment, introduce yourself, your role and qualifications, and check the client's details. This is especially important if you are conducting a telephone assessment, where you may be uncertain of who has answered. Explain the limits of confidentiality and provide the client with an idea of how long the assessment will take and what it will entail. Explain the purpose and structure of LIPI (e.g., time-limited and targeted intervention for mild to moderate psychological problems) and the purpose of taking notes during the session.

Gather Information (10 minutes)

Ask the client to describe their problem, and when it started. Gather enough information to adequately complete the CBT model (e.g., what, who, where, why and when) and identify maintaining cycles. Assess substance and medication use and any prior psychiatric history.

Summarise the problem as you understand it, and seek feedback from the client on the accuracy of the conceptualisation, including information that might be missing. Conduct a risk assessment and any relevant clinical measures (if these were not completed ahead of time). Find out what the client's goals are in presenting now for treatment.

Formulation and Treatment Plan (10 minutes)

Produce a problem statement and CBT model with the client and advise them of the recommended treatment. Find out what the client's treatment preferences are, and provide the client with a summary of the session.

Conclude Session (5 minutes)

Ask the client to summarise the main 'take home' messages from the session. Decide with the client on what the next action(s) will be and make plans for their next appointment. If any referrals to other agencies or providers are needed, this should also be organised.

Example Interview Excerpts

This section provides three excerpts from case examples of assessment interviews in which information is gathered to generate a case conceptualisation and problem statement.

How to begin

The initial assessment interview should start with the clinician introducing themselves, addressing any administrative issues, and explaining the limits of confidentiality. For example:

Clinician: My name is Timothy and I am a psychologist here at the centre. I understand that you have been referred by your GP, is that right?

Client: Yes it is.

Clinician: Before we get started today John, I just want to talk to you for a moment about confidentiality. Everything we talk about together is kept between you and myself, as well as your GP. The exception to this is if I feel you are at risk of harming yourself or someone else, in which case I will need to break confidentiality for safety reasons. Do you have any questions about this?

Client: No, not that I can think of.

Depression

The first example depicts an interaction between a clinician and Dave, a 42-year-old paramedic who has been referred by his GP. The completed formulation model is in Figure 2.2.

Clinician: Would you like to tell me what has brought you in to see me today?

Dave: My GP thought I should see you. I'll be honest, I don't really know why I'm here.

Clinician: Okay. What was the concern that you discussed with your GP?

Dave: I went to see him because I couldn't sleep.

Clinician: Can you tell me a bit more about that?

Dave: It takes me ages to get to sleep and I am always tired when I wake up. Then I am tired for my shift.

Clinician: What is it that you do for work?

Dave: I'm a paramedic.

Clinician: Right. How long has this been happening for you?

Dave: The not sleeping?

Clinician: Yes.

Dave: Well, I've always been bad at sleeping, but it seems to be getting worse as I am getting older.

Clinician: Is there anything else that's bothering you?

Dave: It's not bothering me but my wife says I've lost some weight as well. That's probably a good thing.

Clinician: What is your appetite like at the moment?

Dave: I'm not hungry when I'm tired. I'm not doing anything all day, just watching tv mostly, so I don't get hungry.

Clinician: I see. So you're having a lot of trouble sleeping, you feel tired all day, and you're not really hungry much of the time. Is that right?

Dave: Yeah.

Clinician: Are you sleeping during the day?

Dave: Not really. I find I've missed parts of whatever I'm watching, but I'm not sure that counts as sleeping.

Clinician: What was it about the sleeping problems that made you see your doctor about them now?

Dave: Well, I've used up all my sick days, I keep getting really bad headaches and feeling sick, and so I have to go home early. Then I feel bad because I can't do my shift or someone else has to be called in.

Client: Can you tell me what you mean by feeling bad?

Dave: Guilty I guess, that someone else has to be called in on their day off. Now I am disturbing them and they have their own problems to deal with. You don't want to be that guy who drags the team down, you know?

Clinician: What do you mean by that?

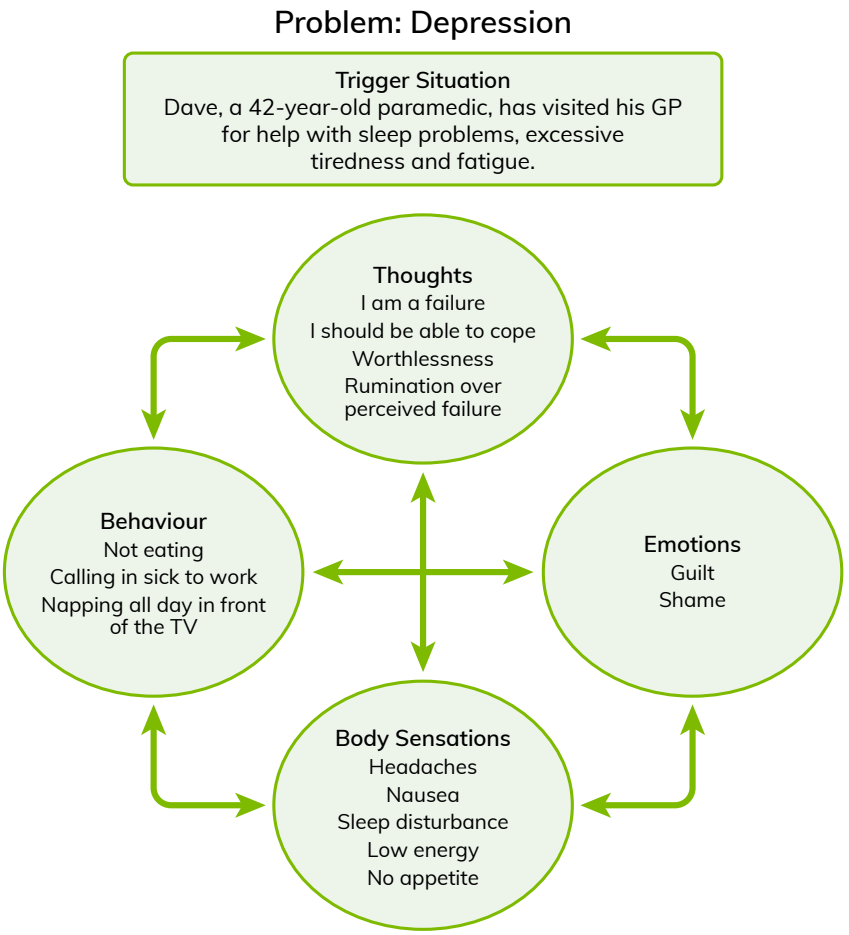

Figure 2.2 Dave's CBT Formulation

Dave: Well, we are all doing the same job. They're probably just as tired as I am. You don't want to be that old guy who can't keep up.

Clinician: What does it mean to you to be that old guy who can't keep up?

Dave: You know, just can't hack it. Can't do things he should be able to do. Becomes more of a burden to everyone, having to fix his mistakes.

Clinician: Do you feel that's how people see you?

Dave: I don't know. I am sure one or two do.

Clinician: How do you feel about that?

Dave: Not great, but I don't blame them. I'm not pulling my weight, so I deserve the reputation.

Clinician: What do you mean when you say you don't feel great?

Dave: Guess I'm a bit of a failure, you know? Everyone else can cope with the job, so what's my excuse?

Clinician: It sounds like you're feeling like you aren't coping well at the moment, but you feel as though you should be. Is that right?

Dave: Yeah.

Although Dave presented initially to his GP for treatment relating to his sleep disturbances, in his LIPI assessment session he has disclosed feelings of guilt and thoughts of failure, in addition to reduced appetite and activity levels. The clinician should administer a measure such as the DASS-21 or K-10 to screen for depression, and should also ask Dave about any active thoughts of suicide or self-harm. The clinician may also want to ask about Dave's alcohol use and whether this has changed recently.

As shown in the Hot Cross Bun formulation in Figure 2.2, there is an interaction between Dave's thoughts, emotions, body sensations, and behaviours. Dave reports spending his day napping in front of the tv, which is likely making it more difficult for him to sleep at night. Because of this, he feels tired in the morning and

unable to get going through the day, resulting in him napping in front of the tv. It also results in him feeling too exhausted to go to work, which in turn causes him to have feelings of guilt and shame about not being at work. He also reports a decrease in appetite, which, in combination with his sleeping difficulties and negative thoughts and feelings, is likely contributing to his headaches, nausea, and lack of energy. These body sensations result in Dave feeling too unwell to go to work. There are several treatment strategies that would be suitable for Dave to help him escape this vicious cycle of symptoms:

- Psychoeducation (e.g., use the formulation to explain what maintains his depressed mood)
- Behavioural activation (e.g., activity scheduling to re-engage Dave with meaningful/pleasurable activities, exercise)
- Mood and activity record to identify patterns in his mood and behaviour
- Sleep hygiene
- Cognitive restructuring

Chapter 3 provides more detailed information about these and other treatment strategies available to LIPI clinicians.

Social Anxiety

This example describes an interaction between a clinician and Katie, a 21-year old student. The completed formulation model is in Figure 2.3.

Clinician: Katie, why have you come in today?

Katie: My boyfriend asked me to see someone.

Clinician: Okay. Why was that?

Katie: We had a big fight after I left his cousin's wedding early.

Clinician: Can you describe for me what happened at the wedding?

Katie: I don't know. Everyone is making a bigger deal out of this than it is. I just didn't want to be at the wedding anymore, so I went home.

Clinician: Why didn't you want to be there?

Katie: I didn't know anyone except my boyfriend and his parents, and they spent a lot of time talking to other guests, so I was left on my own mostly. I'm not really very good at talking to new people, so it was really uncomfortable and boring.

Clinician: What do you mean by uncomfortable?

Katie: I don't know. I just really didn't want to be there I guess.

Clinician: What were you thinking while you were left by yourself?

Katie: I was really hoping that no one would come up and talk to me.

Clinician: Why is that? What might happen if they did?

Katie: I get really flustered when people try to talk to me. I don't know what to say and it makes me really anxious.

Clinician: When you say flustered, what does that look or feel like?

Katie: My heart starts racing. I feel jittery. And my stomach starts to sort of flip out. I worry that I'm bright red and shaking and that the other person is wondering what's wrong with this girl. I get really worried that I am about to be sick.

Clinician: That sounds like a tough situation to be in. Is there anything else you're thinking when this happens?

Katie: I don't know. I guess I feel stupid. I can never think of anything interesting to say to people. I try to plan what I'm going to say, but that doesn't always help. When I do talk it comes out wrong. That's why I usually play with my phone, so they won't talk to me in the first place. It's easier for everyone.

Clinician: I see. What other things do you do to stop people from talking to you?

Katie: I try not to make eye contact.

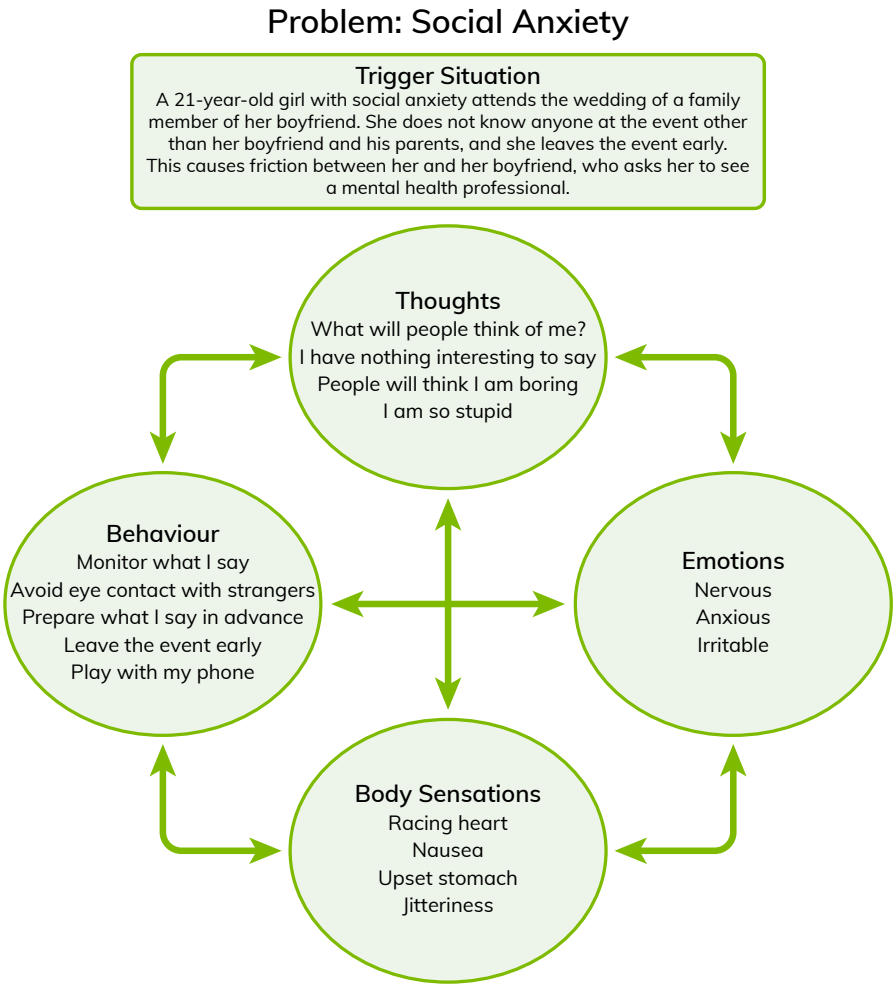

Figure 2.3 Katie's CBT Formulation

Clinician: What do you think people would think if you did talk to them?

Katie: That I am really boring.

Clinician: It makes sense that you would feel uncomfortable in social situations given that you expect that you won't be able to think of anything to say and that other people will think that you are boring. When you feel flustered because someone is talking to you, what do you do?

Katie: Usually I make an excuse to leave.

Clinician: And what happens when you leave?

Katie: I feel so much better as soon as I escape.

Clinician: Escape. That is an interesting word to use. What do you mean by that?

Katie: You know, get out of there. Get away from everyone.

Clinician: So you feel better when you leave the social situation. Are there any negative things that come from you leaving these situations?

Katie: Well, I guess it upsets my boyfriend. He is quite a social person and so we argue a bit about going over to people's houses. Parties are the worst. I usually just don't go, but he hates that. I can't win though. If I go, I usually end up feeling really irritated because I am so anxious, so we argue. But if I avoid going, we argue too.

Clinician: It sounds like this is an issue that comes up often between yourself and your boyfriend. Is that right?

Katie: Yeah. I guess so. I hadn't really thought much about it before.

Katie presented to her assessment session with little apparent insight regarding why she was there, as she attended only after prompting from her boyfriend. With strategic questioning, the clinician has been able to clearly identify the trigger situation. By asking questions about how Katie was feeling, what she was thinking at the time, and what she did in response to the trigger situation, the clinician was able to create a formulation of Katie's problem. The clinician also enquired about how often the problem occurs and what impact it has on Katie's life, and identified that Katie is likely experiencing social anxiety. The clinician should administer a measure such as the Social Phobia Inventory (SPIN) (Connor, Davidson, Churchill, Sherwood, Foa, & Weisler, 2000).

As shown in the Hot Cross Bun formulation in Figure 2.3, there is a clear interaction between Katie's thoughts, emotions, body sensations, and behaviours. Katie has negative thoughts about herself and her social abilities, such as people thinking she is boring or that she never has anything interesting to say. This contributes to her feeling tense, anxious, and nauseous during social situations. Because Katie is nauseous, she worries that she will be physically sick, meaning her attention is on her body sensations, rather than the conversation she is having with other people. As Katie actively avoids engaging with other people (e.g., by instead being occupied by her phone, which is a safety behaviour), she also has more time to ruminate over her negative thoughts, which heightens her body sensations. The body sensations subside when Katie "escapes" the social situation, which reinforces 1) her belief that she is not skilled at social interaction, 2) that social situations are dangerous and must be avoided, and 3) that these uncomfortable sensations can be avoided by not attending the social event in the first place. There are several treatment strategies that would be suitable for Katie to help her feel more confident in social situations:

- Psychoeducation (e.g., use the formulation to explain what maintains her social anxiety, with particular attention given to safety behaviours)
- Relaxation techniques
- Cognitive restructuring using a thought diary
- Behavioural experiments to challenge her fears

Chapter 3 provides more detailed information about these and other treatment strategies available to LIPI clinicians.

Panic Disorder

This example describes an interaction between a clinician and Tony, a 32-year-old engineer. The completed formulation model is in Figure 2.4.

Clinician: Tony, can I get you to tell me a little about why you've come in today?

Tony: Yeah, sure. I don't really know where to start, but I think I might be having panic attacks. I've had them for a while now, but I've started having them at work, and having to take time off. At the start I just took a day or two off here and there, but now it's happening more regularly. I have a senior position at work, so it's not great for me to be away from the office for extended periods of time. I might lose my job.

Clinician: I see. Can you describe the most recent attack to me?

Tony: It was last week. I was driving home from work. I just suddenly felt like I couldn't breathe, and my chest felt tight. It was really painful. There was no warning. There never is. I had to pull the car over because I thought I was going to crash. I called my wife and asked her to call me an ambulance, but she just came to meet me where I was and stayed with me until I could drive home.

Clinician: Can you tell me a bit more about the last time you had a panic attack at work? What was your day like?

Tony: Normal I guess. It's always pretty busy. Lots of deadlines. I probably had a little extra to catch up on, since I'd been away for a week because of a previous panic attack.

Clinician: How did you feel about the extra work?

Tony: I'm used to it.

Clinician: Okay. So how would you describe the day?

Tony: Probably a little more stressful than usual. I was feeling a little anxious about being back, but not because of the work. Like I said, I am used to it.

Clinician: Can you tell me what you were feeling anxious about?

Tony: Having another attack. The last one happened during an important meeting, and I had to make some excuse about feeling unwell to get out of there. I was worried I guess, that it might happen again.

Clinician: So it sounds like you're anxious about having an attack at work. Is that right?

Tony: Yeah.

Clinician: You've mentioned that you've experienced these attacks a couple of times. How long have you been having them?

Tony: The first one was about a year ago. I actually went to the ED that time because I thought I was having a heart attack. My dad died from a heart attack and my older brother had one about 18 months ago, so it's been really stressful.

Clinician: I'm sorry to hear that about your family. What did the doctors say when you went to the ED?

Tony: They ran a bunch of tests, but my heart was fine apparently.

Clinician: I see. What were you doing when you had the first attack?

Tony: I was running with my dog. I used to run every day.

Clinician: You stopped running?

Tony: Yes. I had a few attacks while I was out running, so I stopped going because I was so worried I was about to have a heart attack.

Clinician: When you feel an attack happening, what types of things are you thinking?

Tony: I don't know. Mostly I am scared that I am going to die, that this time will be the time I have that heart attack. I go blank, like I am there but I am not. It's hard to explain. I am kind of frozen with fear. It sounds really stupid. I feel like I need to escape but I can't do anything to stop what's happening. I am just at the mercy of what's going on and I have no control at all.

Clinician: Where do you feel it in your body?

Tony: Everywhere. I feel hot all over. And I sweat horribly. But mostly in my chest. It feels really tight, so I can't breathe. I feel like I am gasping for air, but I can't get any oxygen. It's awful. I always think I am having a heart attack.

Clinician: You mentioned that you stopped running with your dog, as you were worried that you might have a panic attack, or heart attack. Is there anything else you avoid?

Tony: Meetings at work if I can, which is really hard in my job because I have to meet with people all the time. My wife takes care of most of the kids' sports and things, because I don't want to be around the other parents if I have an attack. My GP gave me some medication to help calm me down when I feel on edge, so I carry that with me all the time, just in case. Oh, and I gave up coffee, because I read that caffeine can make you feel jittery.

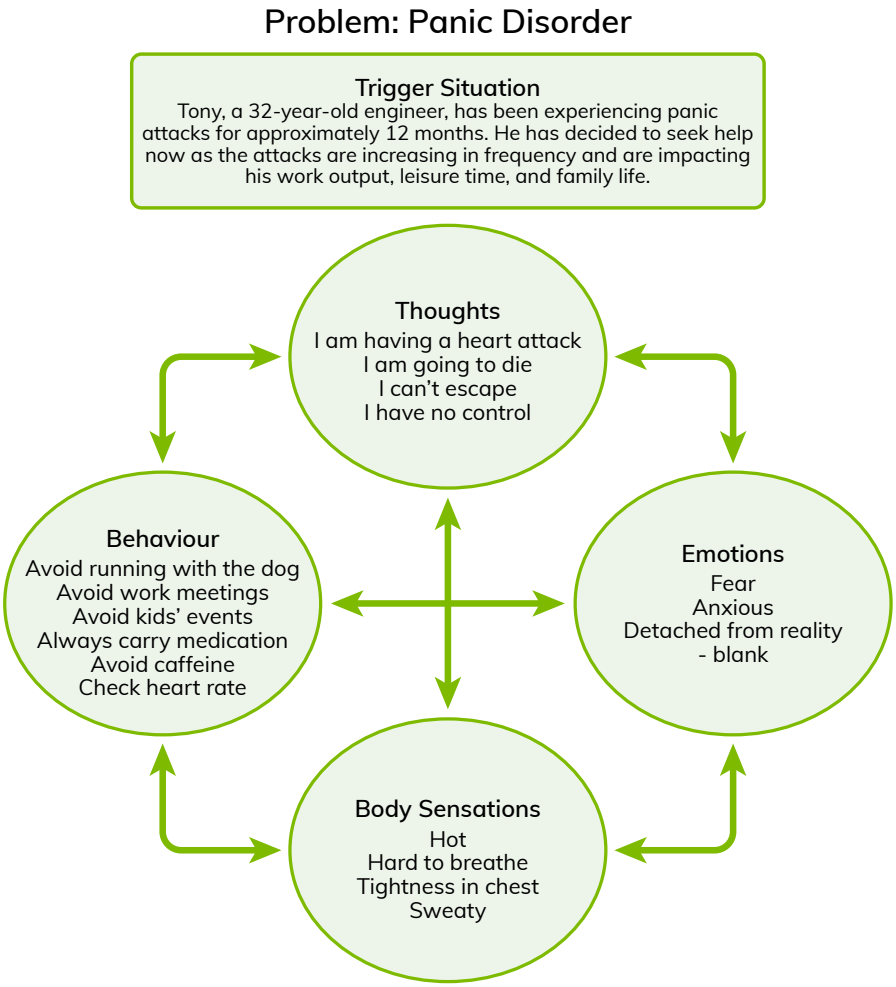

Figure 2.4 Tony's CBT Formulation

Clinician: Okay. After the attack, how do you feel?

Tony: Hmm. Kind of relieved.

Clinician: What do you mean by that?

Tony: I am glad it's over. I survived. I am alive.

Clinician: Anything else?

Tony: Embarrassed that I couldn't control it and worried that people might have seen it. Maybe a bit angry that it happened again. I don't know why I can't tell when it's going to happen.

Clinician: It sounds like you worry that someone might see you during one of these attacks? Is that right?

Tony: Yes, definitely. I have a lot of responsibility at work and people depend on me to be able to make good decisions and be reliable, in control. I can't have people seeing me like that.

Clinician: Would you say you feel more or less anxious when you are around other people?

Tony: More. Only since these attacks started though. I never used to have this problem.

Clinician: Tony, were you concerned about having a heart attack prior to experiencing your first panic attack?

Tony: Absolutely. My father's death was a real wake up call, and then Tom. It's a real concern. I have young kids and I want to be around for them.

Although Tony presented to his assessment session with an understanding that he was experiencing panic attacks, he also appears to have the persistent worry about having a heart attack, like his father and brother. This should be explored further during treatment and in the development of the formulation. Tony may benefit from psychoeducation relating to panic, and how his specific worries about having a heart attack maintain his panic symptoms. The clinician could administer a measure such as the Panic Disorder Severity Scale to learn more about the severity, frequency, and impact of the attacks Tony experiences.

As shown in the Hot Cross Bun formulation in Figure 2.4, there is a clear interaction between Tony's thoughts, emotions, body sensations, and behaviours. Tony first started experiencing panic after his father passed away from a heart attack, and shortly after his brother also had a heart attack. He reports feeling worried about having a heart attack himself prior to experiencing his first episode of panic. Tony describes his panic attacks as feeling as though he was having a heart attack. He actively avoids anything that could simulate these symptoms, such as caffeine and running with his dog, which reinforces the belief that these body sensations are dangerous and should be avoided. Tony also avoids situations in which he has experienced panic previously, reinforcing his belief that he will have an attack in those situations and that he must "escape". Avoidance means he misses out on opportunities to challenge this belief. As some of the situations within which Tony has experienced panic attacks are unavoidable (e.g., meetings at work), his thoughts about not being able to escape and having no control are heightened. Removing himself from the situation leads to the body sensations subsiding, which reinforces Tony's beliefs that 1) the sensations are dangerous, 2) the situations need to be avoided, and 3) he needs to carry medication to treat the symptoms (a safety behaviour). There are several treatment strategies that would be suitable for Tony to help him overcome his panic:

- Psychoeducation (e.g., use the formulation to explain how Tony's fears of having a heart attack and associated symptoms serve to maintain the panic attacks)
- Relaxation techniques
- Cognitive restructuring using thought diaries
- Behavioural experiments to challenge his fears
- Interoceptive exposure and in vivo exposure

Chapter 3 provides more detailed information about these and other treatment strategies available to LIPI clinicians.

Generalised Anxiety Disorder

This example describes an interaction between a clinician and Janet, a 50-year-old school teacher. The completed formulation model is in Figure 2.5.

Clinician: Thanks for coming in today Janet. Can we start by you telling me about why you've come to see me?

Janet: I don't really know. I've been feeling a bit out of sorts lately.

Clinician: Can you tell me a bit about that?

Janet: I've been feeling a bit grumpy. Teary. Which isn't like me.

Clinician: Okay. Can you describe a time when you've been feeling grumpy or teary lately?

Janet: Well, I'm a school teacher you see, and I've been getting snappy at the children, which is unacceptable.

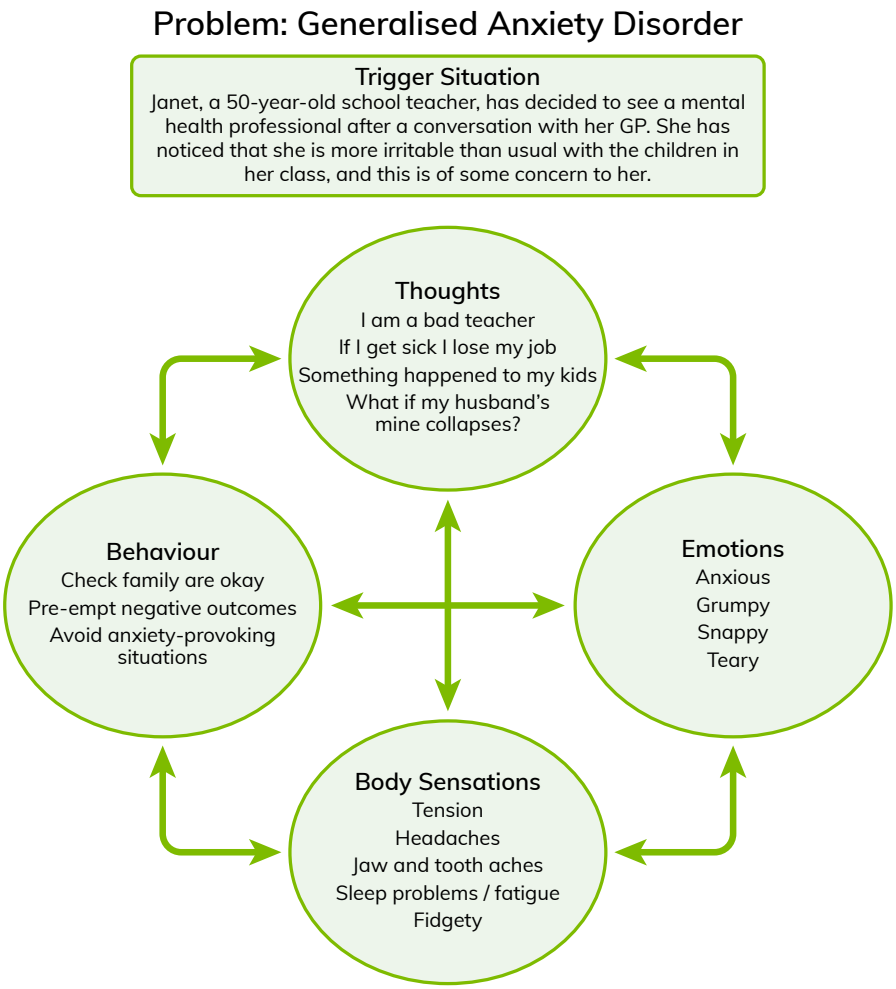

Figure 2.5 Janet's CBT Formulation

Clinician: I see. Are there times when you are more or less snappy, as you put it, with the children in your class?

Janet: Not really. That's why I don't really know what's wrong with me. I don't think the children are misbehaving more than normal. They are kids. That's what kids do sometimes.

Clinician: Are there any other times when you feel this way?

Janet: Sometimes I get angry with my kids.

Clinician: How so?

Janet: Erica has her licence now, and even though I always offer to take her where she needs to go, so that I know she isn't alone and driving, she isn't interested. I worry so much. And I just ask that she tells me when she's going to be driving to and from home, so that I know when to expect her. Of course she never comes home when she says she will, so I worry that she has been in a car accident or something terrible. When she does get home I've been worrying for hours so I am really angry, then we have a fight because she thinks I'm overly controlling. But I'm just worried.

Clinician: That sounds tough.

Janet: It is. After we fight I feel really sad, and then I worry that she's going to move out of home soon too, and I won't see her much. We should be enjoying our time together while we can.

Clinician: You said move out of home too. Did someone in your family recently move out?

Janet: Yes. My son moved out at the beginning of the year to go to university.

Clinician: What was that like for you?

Janet: I hate it. I miss him and I worry that he will get caught up in drugs and partying now that he is in the city. I call him to make sure he's okay, but teenage boys. He never calls me back.

Clinician: It sounds like there has been a lot of change in your family recently. Is that right?

Janet: Yes. I guess so.

Clinician: You've said that you worry about something bad happening to your children – accidents or taking drugs – are there other things you worry about?

Janet: I worry about everything. I never seem to be able to switch it off. I think it used to be easier when I was busier with the children, because I was distracted you know? I had things to do most of the day.

Clinician: I see. Can you describe some of the things you worry about?

Janet: When I see mine site accidents reported on the news I worry that it's my husband's workplace, then when it isn't I worry it will happen to him anyway. I worry that we wouldn't be able to afford our mortgage if interest rates go up, as we are now paying for our son to live in the city and go to uni. My daughter isn't far behind. What else? I worry all the time about losing my job, if I get sick for example. Or now because I'm just not being a nice teacher.

Clinician: That sounds like a lot to deal with. How is your sleep?

Janet: Probably not great, but I've never been a good sleeper.

Clinician: How do you mean?

Janet: It takes me a long time to switch off at night. I can lie there for hours thinking about things.

Clinician: What types of things are you thinking about?

Janet: Worries mostly. Playing out different scenarios, that kind of thing.

Clinician: I just want to check that I am understanding what you're saying. You worry a lot, about a lot of different things, and that these worries keep you awake at night. Is that right?

Janet: Yes.

Clinician: And my understanding is that since your children are now more independent, you feel like your worry has gotten worse?

Janet: Yes, I do think so.

Clinician: Are there any situations or things that help with your worry, times when you can switch off more easily?

Janet: Not really. I have tried because I didn't want to wake up feeling so tired, but I just can't stop thinking, especially at night. And usually that makes me worry about why I'm not sleeping, maybe I have something wrong with me, I should see the doctor, what if the tests find something. It's never ending.

Clinician: You said that you feel "out of sorts" earlier. Do you feel that in your body at all?

Janet: I'm not sure. I do always feel quite tense, I get headaches. Actually, my dentist told me recently that I need to stop clenching my jaw so much. I went in for a tooth ache and jaw pain, I thought I might have something wrong and need a tooth removed. She said I am fine and that I am probably just stressed.

Clinician: Right. Anything else?

Janet: I move around a lot when I'm trying to fall asleep. My husband calls me fidgety. I wish I had that energy during the day. Then I am exhausted!

Janet initially presented to her LIPI assessment on the recommendation of her GP, because she was feeling "out of sorts lately". Through careful and predominantly open-ended questioning, the clinician was able to identify that Janet suffers from an excessive amount of worry. The clinician could administer an outcome

measure such as the GAD-7 to investigate this further. The clinician would also want to ask Janet about her comments of feeling "sad" and "teary", particularly as Generalised Anxiety Disorder (GAD) can occur alongside other problems, such as depression and other anxiety disorders. In addition to her children being more independent and needing her less, Janet mentioned that her husband works on a mine site, indicating that he may spend periods away from the family home (the clinician would need to confirm this). It would also be appropriate to ask her about how she spends her time when she is not at work, and what types of pleasurable activities she currently participants in, if any. Part of Janet's treatment plan might involve having her spend time doing things that are enjoyable and meaningful for her.

As shown in the Hot Cross Bun formulation in Figure 2.5, there is a clear interaction between Janet's thoughts, emotions, body sensations, and behaviours. By attempting to pre-empt the possible negative outcomes of any given situation, Janet is kept awake at night, which causes her to feel more tired the next day due to her inadequate sleep. The ongoing lack of sleep results in Janet being more susceptible to feeling, as she put it, snappy, grumpy, and teary. The anxious feelings she experiences manifest physically as general and specific tension (e.g., headache, toothache, jaw pain) and fidgeting. Because her body is in a constant state of being on edge with anxiety, Janet is suffering fatigue, which can further impact her already disturbed sleep. Spending hours at night thinking about possible negative outcomes also reinforces Janet's belief that this is a helpful behaviour, and that worry prevents bad things from happening. This means that she is more likely to worry about her family's safety, losing her job, and their financial situation. This is a constant feedback loop that serves to perpetuate the cycle of generalised anxiety. There are several treatment strategies that would be suitable to help Janet manage her worry:

- Psychoeducation (e.g., using the formulation to explain what maintains her worry)
- Learning how to accept uncertainty
- Mindfulness/Attention training
- Cognitive restructuring
    - Beliefs and attitudes about worry
    - Beliefs and attitudes about ability to cope
    - Challenging negative thinking styles
- Behavioural experiments to challenge her beliefs
- Problem-solving training

Chapter 3 provides more detailed information about these and other treatment strategies available to LIPI clinicians. The following chapter also provides a completed example Individual LIPI Formulation and Treatment Plan for Janet. A template for clinicians' use is included in Appendix D.

Summary

Assessment is a critical component of LIPIs. It provides the clinician with an opportunity to determine a client's suitability for LIPI treatment, as well as the best modality of treatment for that client. By conducting a planned and structured interview, assessment links the client's problem(s) with their goals, and aids in structuring their subsequent treatment sessions. The client's problem(s) can be identified through the use of appropriate outcome measures and the development of a CBT formulation that includes their thoughts, emotions, body sensations, and behaviours. A problem statement then allows the clinician and the client to collaboratively design a treatment plan that targets active symptoms, is directly linked to the client's own goals, and ultimately improves the client's quality of life.

Chapter 3
Individual LIPI

Individual LIPIs can use a range of psychological tools and techniques that help clients to create behavioural, cognitive, and emotional change. The first part of this chapter describes the process and sequence involved in establishing an individualised LIPI. This includes a decision tree designed to guide a clinician offering individual LIPIs. The second part provides information about specific psychological treatments and techniques. This list is not intended to be exhaustive, but rather a sample of strategies that could be implemented to address a client's individual needs on the basis of their case formulation. For more information on any of these strategies, or for more treatment options beyond those presented in this chapter, please refer to the clinician resources provided by the *Centre for Clinical Interventions* (CCI) on their website (*www.cci.health.wa.gov.au/resources/for-clinicians*). Within this chapter, treatment techniques and resources are applied to the case studies presented in earlier chapters, to illustrate how aspects of each client's case formulation can be matched with relevant treatment options. A table linking common psychological problems with symptoms and psychological treatments and techniques has also been included to assist clinicians in designing their LIPIs.

Sequence and Considerations for Individual LIPIs

Figure 3.1 depicts a decision-tree that encompasses the various aspects covered in this section, with the purpose of guiding clinicians in implementing LIPIs.

Assessment and Case Formulation

As discussed in Chapter 2, the first step in delivering individual LIPIs is to assess the client and determine their current clinical problem and required level of care. Brief clinical measures should be administered at this point to assess symptom severity and prioritise clinical problems. See Appendix A for a table of free-to-use outcome measures for various clinical problems. During the assessment, the clinician might find it helpful to complete the Hot Cross Bun Case Formulation Model (Handout 2.1 – Appendix C) and the Individual LIPI Formulation and Treatment Plan (Handout 2.2 – Appendix D).

Appropriateness for Current Service

After conducting a LIPI assessment and prior to offering any LIPI, the clinician will need to determine if the client's problem(s) can be addressed within the current service. If not, referrals to alternative services may be warranted or the client may need to be discharged back into the care of the GP.

Appropriateness for LIPI

As discussed in Chapters 1 and 2, LIPIs are primarily appropriate for mild to moderate depression and anxiety. However, clients with more complex problems might still benefit from LIPIs that target discrete aspects of their problem(s), particularly if alternative and more intensive treatments are not easily accessible.

For example, LIPIs alone may not be appropriate for clients diagnosed with Borderline Personality Disorder, Posttraumatic Stress Disorder, Bipolar Affective Disorder, or severe Obsessive-Compulsive Disorder. However, supporting these clients to learn some cognitive and behavioural skills may be useful to target difficulties associated with emotion regulation and distress tolerance while waiting for alternative services.

If it is determined that LIPIs are not appropriate to address the current clinical problem(s), higher intensity therapeutic services should be offered, if available. For example, immediate intervention for the treatment of PTSD results in best outcomes and a LIPI would not be appropriate to address such difficulties. In this case, trauma-focused CBT (a higher-intensity service) provided in an individual format by a clinical specialist (e.g., clinical psychologist) would be the most appropriate option. However, a LIPI could be helpful for a client with PTSD who is waiting to see a clinician for trauma-focused CBT. Some clinical discretion will be required to determine the appropriateness of LIPI for the client.

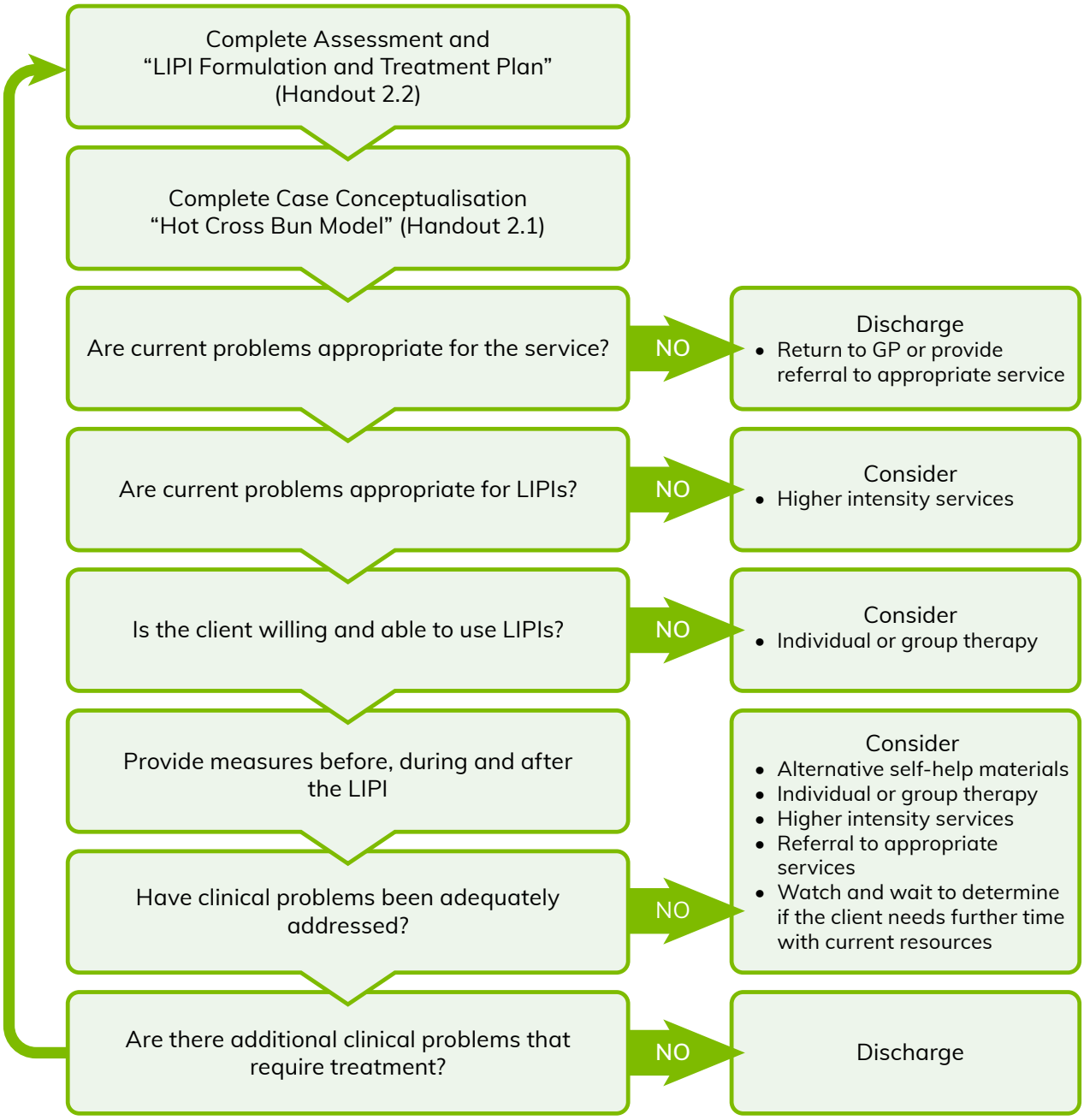

Figure 3.1 *Decision Tree for Implementing LIPIs*

The Client's Ability to Work with LIPI Materials

The next step is to determine if the client is able to work with self-help materials. Chapter 1 provides a range of factors to consider when determining whether LIPIs are appropriate for a client. Considerations for the clinician include:

- The client's level of motivation, engagement and interest. Is the client willing to apply the treatment strategies independently between sessions?
- The format in which self-help materials are provided and if this is accessible by the client (e.g., online, posted materials, email, audio)
- The client's personal preference for delivery mode. Some clients prefer to see someone face-to-face or within a group, whereas other clients prefer online, telephone, or video-conference consultations
- Disability or impairments (e.g., visual, reading, hearing) that may make it difficult to use self-help materials
- Symptom severity and degree of hopelessness
- The amount of guidance the client will need from the clinician to understand and implement the LIPI

Determine Level of Therapeutic Support and Provide Self-Help Materials

Research supports the use of self-help treatments for depression and anxiety, but guidance from a clinician can help clients to engage with the resources. Therapeutic support can be provided via multiple formats, including face-to-face, telephone, email, and/or videoconference. Client preference, clinician opinion, and availability of technology should determine the format(s) of delivery and frequency of contact. Some clients might prefer weekly sessions, while others might prefer fortnightly sessions over a longer period. When providing self-help materials, determine the best format of delivery (e.g., printed materials such as a book or handouts, online) based on the client's preferences, learning style, and accessibility. The clinician's role is to provide the self-help materials in the most accessible format, to guide the client to ensure they understand the principles and procedures of the intervention, and to encourage the client to practice implementing the strategies within (if time permits) and between sessions.

Clients presenting for psychological treatment may be anxious or lost in their own thoughts as a result of worry or rumination (Chellingsworth, Kishita, & Laidlaw, 2016). Ensuring the client is actively participating in the session when using face-to-face LIPIs, for example by asking them to repeat information back to show their understanding, can focus their attention in the moment. The client should be actively participating in the conversation every few minutes, with the clinician deliberately seeking feedback to ensure they have a shared understanding of the client's problem (Chellingsworth et al., 2016). No one knows the client better than they do; they are the expert in their own experiences (Williams and Chellingsworth, 2010). Asking the client to describe the 'take home messages' at the end of the session is helpful for checking the client's understanding and for the client to consolidate new learning.

LIPI Scope

The clinician should not expect clients' symptoms to always fully resolve over the course of the LIPI. Instead, the clinician's aims should be to ensure that the client has:

- The psychoeducational materials required to understand their clinical problem(s) and factors that maintain the distress they are experiencing
- An understanding of specific skills they can apply to better manage their problem(s), even after their LIPI treatment concludes
- An opportunity to practice the skills with the clinician's guidance
- Some confidence that if they continue to apply the skills their clinical problems will improve

LIPIs require considerable commitment from clients. Clients are responsible for implementing the strategies they learn between treatment sessions and continuing to apply them once the sessions end. LIPI sessions initiate the client's process of change; they are not the end of the process. As such, LIPI clinicians do not need to continue seeing clients until their symptoms completely resolve and clients should be aware that this is the case. LIPIs are designed to promote the client's coping self-efficacy, rather than foster dependence on the clinician. The next section of this chapter (Psychological Tools and Techniques for LIPI) provides information regarding specific techniques that can be implemented to achieve this.

Identifying Appropriate Tools and Techniques

The tools and techniques the clinician chooses to implement with the client should be guided by the case formulation. However, the first step will usually be to provide written and verbal psychoeducation, which includes information about the diagnosis or clinical problem(s) in addition to a copy of the individualised case formulation. Psychoeducation will help the client to understand their current difficulties and the role that problematic thoughts and behaviours play in maintaining their distress. Psychoeducation can also provide the client with hope, and the knowledge that changing their thoughts and behaviours can improve their problem(s). Motivation can be increased by offering the client a variety of treatment options and allowing them to select the skills they believe will be most helpful for them. Limiting the number of key skills covered during the LIPI may help the client achieve mastery. For instance, the client and clinician might select only one cognitive (e.g., cognitive restructuring), one behavioural (e.g., exposure or behavioural activation), and one physiological (e.g., exercise or relaxation) strategy to address symptoms in the individualised case formulation. The next section of this chapter (Psychological Tools and Techniques for LIPI) provides information regarding commonly used CBT strategies for the treatment of depression, anxiety, and sleep disturbance.

Have Clinical Problems Been Appropriately Addressed?

After the planned number of sessions have been conducted, the clinician should review the client's scores on the outcome measures and seek qualitative feedback from the client to determine if the targeted problem(s) have been appropriately addressed. If they have been addressed, discharging the client can be considered. If the clinical problems have not been addressed adequately, consider additional self-help materials, individual therapy (e.g., face-to-face, videoconference, telephone), group therapy, higher-intensity therapeutic services, or a referral to alternative service. Given that LIPIs are brief interventions, also be mindful that the client may need more time to continue applying the skills before seeing a measurable or noticeable impact. If this is the case, the client may be discharged in the knowledge that they can return to the service if required. Alternatively, a follow-up session may be scheduled (e.g., after one month) so that the clinician can assess the client's progress before discharge.

Tracking Outcome Measure Scores

The following example demonstrates how a clinician could use the K10 to track the client's progress throughout the duration of treatment.

Case Example – Outcome Measure – Dave

The clinician decided that the K10 would be helpful for tracking Dave's depression and anxiety symptoms each session. Dave completed the K10 during his initial assessment (baseline), at four subsequent sessions, and again at a 1-month follow-up session. Figure 3.2 shows Dave's scores over time. The clinician noticed that there was not much change between his assessment score and his first treatment session, and a slight change between the first and second treatment sessions. However, Dave's symptoms consistently reduced in severity from the second session onwards. Dave and the clinician reflected on and discussed the graph at every session. By his one-month follow-up, Dave's symptoms were in the minimal range (e.g., a score lower than 20), as indicated on the graph. If Dave's symptoms had not started to reduce by his third or fourth session, the clinician would have carefully reviewed the formulation with him to identify any aspects of the problem that were not being targeted by the treatment plan. Dave and his clinician were confident that if he continued to apply his new skills his mood would continue to improve and he would be better equipped to respond to stressors in the future, so treatment was mutually ended at this point.

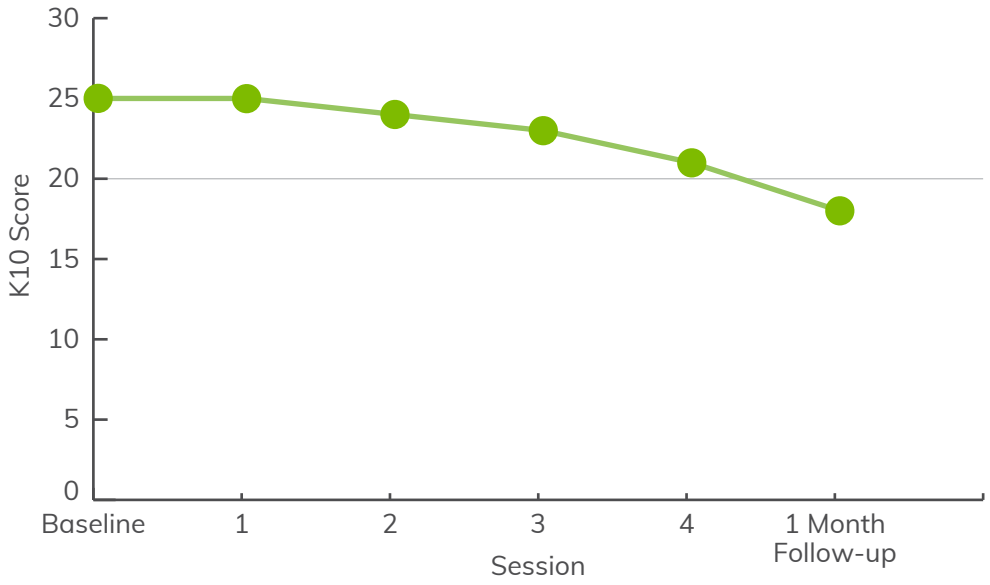

Figure 3.2 Dave's K10 Scores During Treatment

Are There Additional Clinical Problems Requiring Treatment?

If the client reports another clinical problem that was not resolved during treatment, the clinician can return to the start of the decision tree to develop a new formulation and treatment plan.

Setting and Reviewing Homework

Homework is an essential component of CBT. This is especially the case for LIPIs, because the brevity of treatment means that clients need to assume most of the responsibility for applying their new skills. Research shows that the completion of therapeutic homework improves clinical outcomes (Kazantzis, Deane, Ronan, & L'Abate, 2005). It is important for clients to understand that the degree of benefit they receive from their treatment will be highly correlated with how frequently they apply their new skills between sessions. Indeed, LIPIs are not necessarily low intensity from the client's perspective; they require considerable effort. For clients to be motivated to independently apply treatment strategies, they need to understand how the homework tasks are relevant to their problem(s) and will help them to improve their wellbeing.

Clients do not attend therapy to feel better only while in the clinician's office. Homework allows clients to translate what they have learned from their psychoeducation and therapy sessions into action, so that the principles and skills can have a positive impact on their quality of life. A client's confidence in their ability to apply their new skills and successfully manage their problem(s) will largely develop through completing their homework. Monitoring forms can be very helpful for consolidating new learning during homework, and these can be reviewed in therapy sessions.

Homework should be reviewed at the beginning of each therapy session. At this time the clinician can reinforce homework completion, review new learning, help to design follow-up tasks, provide corrective information, and problem-solve obstacles to homework completion if required (e.g., time restrictions, family responsibilities). By reviewing homework at each session, the clinician is reinforcing the importance of the homework tasks, which will ideally increase adherence. New homework tasks should be collaboratively designed at the end of each session to ensure there are plans to apply the skills. The role of a LIPI clinician is to provide support and encouragement while introducing and reviewing relevant resources and strategies to address the client's current difficulties. A large focus of therapy in this context is on the skills and strategies being provided, many of which will be applied between therapy sessions. If time permits, it may be useful for clients to practice the skills with the clinician first, either within or outside of the clinician's office.

Ending the LIPI

LIPIs are short-term treatments suitable for mild to moderate mental health problems. By design, clients attend a limited number of sessions, where the role of the clinician is to provide expert support to the client while the client undertakes the bulk of the work through self-help materials. Although clients should be aware at the beginning of treatment that they will attend a limited number of sessions (e.g., 3-5 sessions), discussing the end of therapy in advance is recommended. Some clients feel angry, anxious, or even sad at the end of treatment; this is normal. These emotions may be attenuated by being open and honest about

the duration of the LIPI and the end of treatment. The final session should involve revising the client's goals, what they have accomplished so far, and how they can continue to see improvements after their final LIPI session. If the service has the capacity to offer follow-up sessions, this can also be offered to the client.

Psychological Tools and Techniques for LIPIs

This section provides LIPI clinicians with a range of psychological tools and techniques that can be matched to a client's individual needs as indicated by their case formulation. Case examples are presented throughout to demonstrate how symptoms can be targeted with specific treatment strategies. As stated earlier, this is not an exhaustive list, but rather a sample of common and effective treatment approaches to psychological problems such as mild to moderate depression and anxiety. Two more case studies are provided in addition to those presented in Chapter 2. The assessment information for each of these clients is linked with the treatment options presented through the rest of this chapter. For further examples of symptoms, treatment options, and clinician resources, see Appendix B.

Additional Case Studies

Todd – Depression

Todd is a 28-year-old male. His girlfriend, Emily, brought him to his GP as he was spending considerable time in bed following the loss of his job. She mentioned that he often refused to leave the house and that he had disengaged from activities that he previously enjoyed, including rock climbing, spending time with friends, and going out to dinner with Emily. Todd mentioned that he felt very down most days, felt tired, and did not feel he had the energy to go rock climbing or see his friends. Instead, he preferred to stay home in bed or play computer games. Although Todd lived with his girlfriend, she worked FIFO (2 weeks on, 1 week off), and she was concerned that when she was not home, Todd would isolate himself and spend most of his time in bed. Todd's GP referred him for psychological assessment and intervention. Following assessment, Todd was diagnosed with Major Depressive Disorder.

Following the decision tree it was determined that the clinical problems Todd presented with were appropriate for the current service, and that a LIPI may be useful to address his depression symptoms. The next step would be to determine whether or not Todd is able to work with self-help materials. Following a discussion with Todd to determine his preferences, it was clear that his motivation was low, and his symptoms of low energy and poor concentration may not be conducive to him working on his own with self-help materials. As such, it was determined that the use of self-help materials guided by limited individual face-to-face sessions may be better matched to Todd's current level of need.

Marie – Anxiety and Panic

Marie is a 53-year-old mother of two adult children with her husband, John. She has been referred to the service on multiple occasions for the treatment of panic disorder with agoraphobia. Due to previous medical issues, Marie suffers from incontinence and as such is worried about being in a situation outside the comfort of her home where she will suddenly need access to a toilet. She has found it extremely difficult to leave the house, and she experienced a panic attack while doing the grocery shopping approximately 6 months ago. Since this time, Marie has rarely left the house in fear that she will lose control or experience another panic attack.

Following the decision tree, the clinician identified that Panic disorder with Agoraphobia was an appropriate clinical problem to address within the current service, and that a LIPI may be useful to address this difficulty. Following discussion with Marie, she mentioned that she has found it extremely difficult to get to the appointments in the past. As such, she has cancelled or not attended for fear of experiencing a panic attack on the way to or during the appointment. Despite being quite motivated to receive help, she appeared to be highly avoidant of attending therapy appointments, and as such it was determined that self-help LIPI may be a useful alternative for Marie.

Marie mentioned that she would like to have some support and was disappointed that she did not feel able to attend face-to-face appointments at this time. With the help of her children, Marie mentioned that she would like to try the use of weekly videoconferencing with a clinician to support her use of self-help LIPI.

Problem Statement and Goal Setting

Following assessment and formulation, the clinician and client will have identified the specific issues that need to be targeted with the LIPI. The client should be given psychoeducation about their clinical problem, and an individualised formulation (e.g., Hot Cross Bun Case Formulation Model – Handout 2.1 – Appendix C), which will increase insight into how their thoughts and behaviours are maintaining their problems and provide a clear rationale for learning the LIPI skills.

In addition to enhancing choice of treatment strategy, the problem statement (see Chapter 2) is an ideal starting point for the client to work with the clinician to generate their treatment goals. It may also be useful to ask the client about how their current problem is impacting on the valued areas in their life. This is where both the clinician (expert in clinical problems and maintenance factors) and client (aware of illness and impact on current life) can work collaboratively to determine treatment priorities. The SMART acronym can help with developing goals that are more likely to result in successful outcomes. Table 3.1 describes the SMART acronym.

Table 3.1 SMART Goals

Feature	In Practice
Specific	Ensure the goal to be achieved is clear and specific. Specify what the client would like to achieve as well as how it will be achieved.
Measurable	Include some form of measurement to see if the goal has been achieved as well as to track progress.
Achievable	Goals should be achievable and within reach so as not to set up the client to fail.
Relevant	Goals need to be relevant to the client's life to build motivation to achieve them. Try to identify changes that would really make a difference and are relevant to the current difficulties.
Time limited	Identify a time that the goal is to be achieved by. It would be ideal to set short, medium, and long-term goals over time, but given LIPI are brief interventions, short-term goals may be more appropriate in this context.

Goal Setting Case Study – Todd

Todd's problem areas:

Todd identified his main problem areas as being his relationships and recreation. He noted that he would like to be more involved in his relationship with Emily, and to enjoy activities with her.

Todd's problem statement:

My main problem is that I am feeling very down and inadequate since losing my job. I don't want to be judged by my friends who seem to be doing really well in their careers. I am also feeling quite tired and do not have the energy or motivation to do the things I previously enjoyed. As a consequence, when Emily is away for work, I am isolated at home and left to think about how much of a failure I am, and I end up feeling worse.

Todd set the following goals to achieve by the end of his LIPI:

- Improve the way I think about myself (self-esteem) and my mood (measured by the K10)
- Catch up with my friends in person at least once a fortnight
- Go out for dinner with Emily when she returns home from work
- Return to rock climbing on Tuesday evenings

Motivational Interviewing

It is important to be compassionate about any apprehension, anxiety, and fear clients may feel about change, and to reinforce that these emotions are normal. Motivational interviewing is a technique used to help clients with low motivation for change. It encourages exploration of ambivalence and can be a very powerful tool by which to foster engagement with treatment (Miller & Rollnick, 2013). Prochaska and Di Clemente's (1984) stages of change model (see Figure 3.4) recognises that clients may present in different stages of 'readiness for change'. Identifying where the client is in the stages of change model may also assist in appropriately matching specific interventions and skills. For example, if the client is in the pre-contemplation stage of change, where they do not see there is a problem needing to be changed, they are unlikely to engage in skills training or present for treatment at all. Clients in the contemplation stage, where they recognise the problem but are ambivalent about change, may benefit from motivational interviewing strategies and change decision worksheets, along with psychoeducation. In contrast, if the client is in the preparation or action stages they are more likely to be ready to fully engage in skills development.

The *Black Dog Institute*[1] offers some useful resources and further reading regarding the stages of change and goal-setting at each stage of change within the model. A simple 2x2 table (see Figure 3.3) can be completed by the client to help them to identify pros and cons for changing and not changing. This can be done as a homework task or in session with the guidance of the clinician, depending on the needs of the client. Ideally, by working through such an activity, the client would begin to move in the direction of positive change.

Thing to be changed: Worrying about bad things happening	
Pros for changing • Feel less tense and anxious • Sleep better and be happier • Be less 'snappy' at children in my class	**Cons for changing** • Will take time • Will be hard
Pros for not changing • Don't have to practice homework • Feels comfortable to worry • No change to current routine	**Cons for not changing** • Satisfaction with work won't improve • Relationship with my children will become more strained

Figure 3.3 Pros and Cons Table – Case Example for Janet

1 *www.blackdoginstitute.org.au*

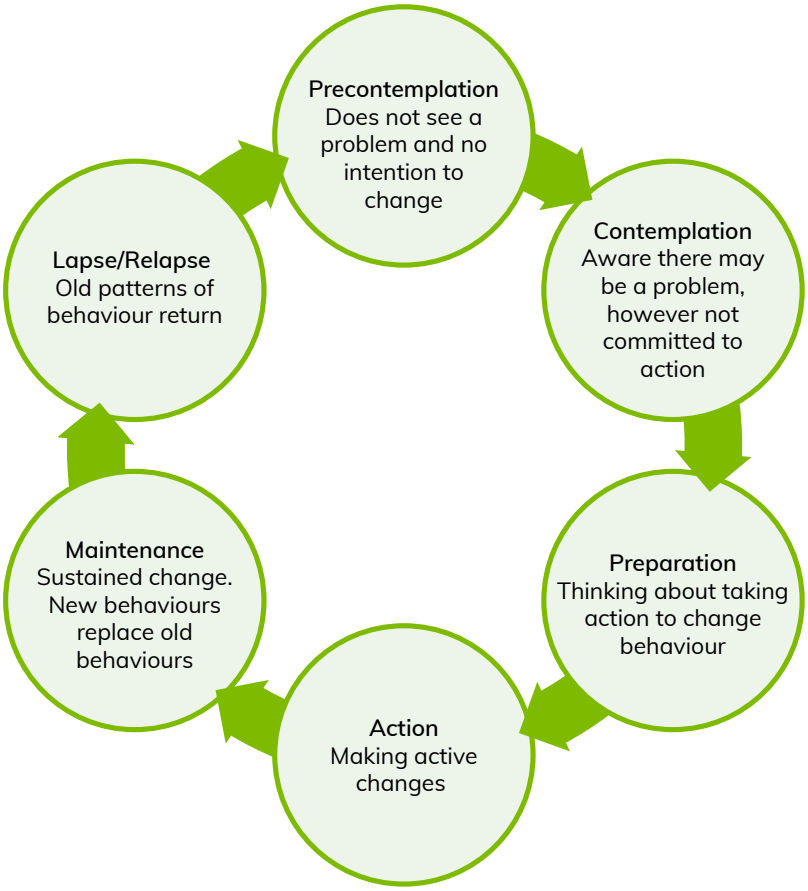

Figure 3.4 Stages of Change model. Adapted from Prochaska & Di Clemente (1984).

Administer Baseline Measures

Baseline outcome measures should be administered prior to implementing any intervention and at each treatment session to monitor symptom change. Appendix A includes a table of free-to-use outcome measures for various clinical problems. The outcome measure administered at treatment sessions should be relevant to the client's specific problem(s). For example, the PHQ-9 is suitable for monitoring symptoms of depression, the GAD-7 for monitoring symptoms of anxiety, and the K10 is a good transdiagnostic measure suitable for clients experiencing multiple problems. The outcome scores can be graphed for the clinician and the client to monitor treatment progress.

Psychoeducation

Psychoeducation is an essential part of psychological interventions and involves the sharing of information (e.g., aetiology, maintaining factors, symptoms, consequences) of a particular clinical problem prior to undergoing skills training. Psychoeducation can be a low cost, easily administered, and accessible initial step to treatment, which can facilitate client engagement with health professionals and the LIPI. The content of psychoeducation typically includes specific information about symptoms, predisposing, precipitating, and perpetuating factors, medication and treatment options, and prognosis. In addition to increasing knowledge and insight, psychoeducation can help to normalise the client's problem and reduce stigma, as the client starts to understand that their difficulties are common and treatable rather than shameful.

Psychoeducation can be provided in a number of formats, including leaflets, emails or websites, workbooks and self-help materials, single session or multi-session group interventions, and individual therapy. Meta-analyses and systematic reviews have shown that both passive (self-help materials) and active (clinician provided) psychoeducation for the treatment of depression and psychological distress can provide rapid symptom relief, and improve treatment outcomes, treatment adherence, and psychosocial functioning (Donker, Griffiths, Cuijpers, & Christensen, 2009; Merry, McDowell, Hetrick, Bir, & Muller, 2004; Tursi, Baes, Camacho, Tofoli, & Juruena, 2013).

Case Example – Psychoeducation – Janet

Psychoeducation broadly links to all components of the Hot Cross Bun model. It helps the client to understand how these components work together to maintain their distress, and provides an understanding of why they feel as they do right now. This understanding provides hope that their situation can be improved.

In the case of Janet, who was suffering from excessive amounts of worry, she had little insight regarding factors that maintain her problem. She presented to her GP with concerns regarding her 'irritable mood'. By providing Janet with psychoeducation materials regarding ***generalised anxiety*** and ***worry***[2], she could begin to understand how her tendency to worry was impacting on her physically (tension, poor sleep hygiene) and emotionally (irritable).

The Centre for Clinical Interventions has two helpful demonstration videos on working with a client experiencing anxiety. The first video shows how a clinician can ***explain the vicious cycle of anxiety,*** and the second shows how a clinician can explain to a client how to ***reverse this cycle***.[3]

Self-Monitoring

Self-monitoring is an essential component of CBT. It is a source of ongoing assessment that enhances the client's self-awareness (Barlow, 2008). If monitoring suggests that the client is not progressing as expected for a positive outcome, interventions can be modified accordingly. Self-monitoring can be useful across a range of client difficulties and incorporated within skills training. In this chapter several examples of self-monitoring records have been incorporated into the treatment case studies. They include:

- ***Monitoring subjective units of distress (SUDS)***
- Monitoring SUDS when incorporating ***relaxation strategies***
- ***Thought diaries***
- ***Sleep diaries*** to monitor ***sleep hygiene***
- ***Mood monitoring*** before, during, and after completing scheduled activities during ***behavioural activation***
- Daily mood monitoring can also be useful for identifying times of the day when symptoms are better or worse. Identifying patterns can help the clinician and client identify reliable triggers of mental health problems, which can then be problem-solved.

Cognitive Restructuring

Cognitive restructuring is a process that assists the client to identify, question and re-frame their negative thoughts (or cognitive distortions). The client learns to identify negative thoughts and unhelpful thinking patterns, then modify them to become more helpful, balanced, and accurate. This in turn leads to an improvement in mood. Cognitive restructuring has been identified as an effective skill in the treatment of many mood and anxiety disorders (Barlow, 2008). The Hot Cross Bun model is useful for introducing the idea that thoughts can influence mood, behaviours, and physiological symptoms, rather than the situation itself directly causing changes in mood. To facilitate the client's understanding of this model, it may be useful to demonstrate it via a neutral example, such as the example provided (see Introducing Cognitive Restructuring).

Once the client has developed an understanding that thoughts can influence feelings, they can be taught how to "tune in" to their own thoughts. This can be achieved with the use of thought diaries, which require the client to keep a record of situations, moods, and thoughts. Thought diaries assist clients to identify personally relevant connections between the 1) trigger/situation (antecedent), 2) thoughts (beliefs), and 3) feelings, behaviours, and responses of others (consequences). They also help in identifying patterns in their thinking or automatic thoughts that tend to reoccur. Once the client begins to recognise thinking patterns, they can be introduced to the concept of unhelpful thinking styles and the 'restructuring' component. Restructuring involves disputation, whereby the client identifies the evidence for and against a specific thought and questions the veracity of the thought. The client then formulates a more balanced thought based on disputation, re-rates the strength of emotion that the new balanced thought elicits, and finally re-rates the strength of belief in the initial thought.

2 *Psychoeducation resources available from www.cci.health.wa.gov.au/resources/for-clinicians*

3 *The Centre for Clinical Interventions YouTube channel can be found at youtube.com/c/CentreforClinicalInterventions*

Case Example – Cognitive Restructuring – Dave

Cognitive restructuring links directly to the 'thoughts' component of the Hot Cross Bun model.

Dave presented to his GP with depressive symptoms, and specific concerns regarding poor sleep and fatigue. During the assessment he indicated that he had thoughts such as "I'm a failure" and "I should be able to cope". After providing some psychoeducation, the clinician could ask Dave to keep a ***thought diary*** to monitor his thoughts for a week, and then use this in the next session to explore his ***unhelpful thinking styles***, explaining how his thoughts (e.g., "I'm a failure") lead to him feeling guilt and depression, in turn decreasing his motivation to participate in work or leisure activities. Dave and the clinician could then work together to challenge his ***unhelpful thinking***[4] using a ***thought challenging record*** and develop ***balanced thoughts***.

The Centre for Clinical Interventions has several helpful demonstration videos showing how clinicians can ***explain the vicious cycle of depression***, explain how to ***reverse the vicious cycle of depression***, and ***work through a thought diary*** with the client.[5]

Introducing Cognitive Restructuring – A Neutral Example

Invite the client to imagine that they are at a theme park waiting in line to go on a new rollercoaster ride (trigger situation). Ask how this situation makes them feel, and then how other people might feel? A range of different emotions (e.g., terrified, excited, happy, nervous, apprehensive) depending on the client's background, temperament, and previous experiences with rollercoasters and theme parks could be expected. Share with the client that other people may have a similar or different response to them, and enquire why they think two people in the same situation could have completely different emotional and physiological responses.

With some prompting, a range of thoughts that may account for these differences can be generated. For example, Person A who feels excited may be thinking "This is going to be the best ride! I'm going to have so much fun!", whereas Person B who feels terrified may be thinking "The safety bars on the rollercoaster are going to fail and I'll fall out!" These two responses may generate different behaviours, with Person A getting on the rollercoaster and Person B running as far away as they can (e.g., avoidance)! Avoidance will prevent Person B from gathering any evidence that does not support the feared outcome (the safety bars do not fail, and they do not fall out), so the fear of roller coasters will remain. You can ask the client to consider the trigger, thoughts, behaviours, emotions, and body sensations for Persons A and B using the Hot Cross Bun model. How can two people have such different behavioural and emotional responses to exactly the same trigger? The answer is in the very different interpretations (thoughts) the people have about the situation.

Behavioural Activation

Behavioural activation links directly to the behaviours component of the Hot Cross Bun model. It is most commonly used to treat depressive symptoms, with several systematic reviews and clinical trials supporting the use of behavioural activation in the treatment of depression (Dimidjian et al., 2006; Ekers, Richards, & Gilbody, 2008; Richards et al., 2008).

Behavioural activation is a form of behavioural therapy that focuses on reducing negatively reinforced avoidance. Negative reinforcement means that something the client experiences as aversive (e.g., anxiety or depression symptoms) is reduced in the short term by avoiding a situation, which then reinforces (increases the frequency of) the avoidance behaviour over time. The problem with avoidance is that it reduces opportunities for pleasure and mastery, and prevents negative thoughts from ever being challenged (e.g., "My mood will never improve!"). The more people withdraw from previously enjoyed activities, the more depressed they will become over time. Behavioural activation encourages clients to reverse this cycle by reducing avoidant behaviours and instead engaging in valued activities with the aim of improving their mood. The client is encouraged to make changes that:

- Increase engagement in both enjoyable and achievement-based activities

4 *Cognitive restructuring resources available from www.cci.health.wa.gov.au/resources/for-clinicians*

5 *The Centre for Clinical Interventions YouTube channel can be found at youtube.com/c/CentreforClinicalInterventions*

- Decrease engagement in behaviours that maintain depressive symptoms (e.g., avoidance of social contact, neglecting responsibilities, too much sleep)
- Incorporate problem-solving to identify and address barriers that may limit psychological rewards from increased engagement (Dimidjian et al., 2011)

Case Example – Behavioural Activation – Todd

In the case of Todd, who was experiencing depressive symptoms, ***behavioural activation***[6] could be used to increase his activity levels, as he reported being very inactive during his assessment. Clients often think they will become more active once they feel better, however, behavioural activation can actually help the client to feel better. Action usually needs to precede motivation, rather than the other way around. For Todd, the clinician could explain the ***vicious cycle of depression*** and how behavioural activation may help to reverse the cycle and improve some of his symptoms.

Behavioural activation needs to be adapted to suit each client and incorporate activities that are aligned with their goals and important areas within their life. For Todd, his behavioural activation could be linked to his goal of going rock climbing on Tuesday evenings. By personalising the task, the client is more likely to be successful. If Todd had not been able to generate his own task idea(s), the clinician could have shared the Centre for Clinical Intervention's ***fun activities catalogue*** with him. This resource offers 360 ideas for pleasant and achievement-based activities to incorporate into activity scheduling tasks and weekly activity scheduling sheets.

The Centre for Clinical Interventions has several helpful demonstration videos designed for clinicians who are incorporating behavioural activation into a treatment plan. ***Part I*** illustrates how weekly activity monitoring can be introduced with a client; ***Part 2*** illustrates reviewing the weekly activity monitoring with the client; and ***Part 3*** introduces behavioural activation to the client.[7]

To effectively incorporate behavioural activation, the following may be helpful:

- Assist the client to understand the cycle of depression
- Identify behaviours that may be maintaining depressive symptoms
- Incorporate daily monitoring of mood and activities (see Self-Monitoring)
- Introduce activity scheduling consistent with goals and values (incorporating a balance of achievement-based and enjoyable activities)
- Continue to monitor mood before and after activity scheduling
- Use problem-solving strategies to manage barriers to behavioural activation

De-arousal Techniques

De-arousal can be particularly helpful for anxiety symptoms. These techniques link directly to the body sensations component of the Hot Cross Bun model. Two commonly used de-arousal techniques are breathing retraining and applied relaxation (progressive muscle relaxation), both described in the case studies below. Barlow (2008) is a good resource for clinicians wanting to incorporate these strategies into their treatment plans.

6 Behavioural activation resources available from www.cci.health.wa.gov.au/resources/for-clinicians/depression

7 The Centre for Clinical Interventions YouTube channel can be found at youtube.com/c/CentreforClinicalInterventions

Case Example – Breathing Retraining – Katie

Breathing retraining is a form of de-arousal that is intended to reduce physical symptoms of anxiety. When breathing rate quickens, the balance of oxygen and carbon dioxide changes, which heightens the experience of anxiety and loss of control. This biological change causes sensations such as weakness, dizziness, and light-headedness. Breathing retraining helps the client to regain control of their breath and restore the oxygen-carbon dioxide balance.

In the case of Katie, who was experiencing social anxiety, breathing retraining could be introduced so she has a strategy for managing her body sensations when she is anxious. Practicing this technique could help Katie to feel less anxious generally, but also, after enough time, to reduce her anxiety during a trigger situation (such as attending a party). The clinician could ask Katie to keep a ***daily record*** of her breathing to help her to tune into her breath.

Case Example – Progressive Muscle Relaxation – Janet

Progressive muscle relaxation, or applied relaxation, is a technique that involves tensing a muscle and then relaxing. It is repeated one body part at a time until a state of relaxation is achieved.

In the case of Janet, who was experiencing a lot of muscle tension as a result of excessive worry, this technique could be introduced to help her to relax. By doing this at night before bed, Janet might also improve her sleep. The clinician could ask Janet to ***monitor her levels of relaxation***[8] so that she can get a sense of when and why she is more or less relaxed.

Exposure

Exposure exercises are useful for treating a range of anxiety disorders and symptoms. These exercises involve confronting a feared situation and challenging perceived threats (negative thoughts). This improves the client's confidence in managing anxiety and distress (Barlow, 2008). Prior to conducting exposure exercises, it is a good idea for the client to be familiar with the Subjective Units of Distress Scale (SUDS). The client will need to become attuned to rating their anxiety or distress on a scale of 0 (completely calm and relaxed) to 100 (highest anxiety/distress ever experienced). The use of the SUDS may also assist with challenging 'black and white' thinking (e.g., either anxious or relaxed), allowing the client to see 'shades of grey' (e.g., SUDS rating of 30). This may help them to feel more confident in managing feelings of anxiety or distress. The SUDS can also assist both the client and clinician to monitor change in anxiety during an exposure task and progress over time.

Clients often try to cope with anxiety by avoiding the object, activity, or situation they fear. Although avoidance might help to reduce the anxiety in the immediate and short-term, it maintains or worsens the anxiety over time as cognitive distortions are left unchallenged; the client is unable to learn that fears are unlikely to actually happen, or that they can cope if the feared situation does happen. Clients also do not have the opportunity to learn that they can cope with physical and emotional discomfort. It is important to identify objects, activities, and situations that clients are avoiding, and then support the client to gradually confront these triggers. Sometimes avoidant behaviours are obvious (e.g., client avoids catching public transport), however, safety behaviours are more subtle avoidance behaviours that clients use in the presence of a trigger. Table 3.2 provides several examples of safety behaviours, their function, and the outcomes of using them.

In Vivo Exposure.

In vivo exposure involves repeated direct exposure to real-life feared situations. During in vivo exposure therapy, the client is initially exposed to the feared object, activity, or situation with the support and guidance of the clinician. This form of exposure is often undertaken through a graded format where the client constructs a hierarchy or step ladder of feared stimuli, ranked according to their predicted SUDS rating. This type of exposure may be used across a variety of clinical problems, including anxiety (such as where the client may have the goal to give a speech at a wedding), phobias (such as a fear of needles/injections), and OCD (such as the fear of contamination). To incorporate in vivo exposure, the following steps need to be undertaken:

- Identify feared/anxiety-provoking stimuli.
- Identify any safety behaviours that prevent the effectiveness of exposure tasks.

8 *De-arousal resources available from www.cci.health.wa.gov.au/resources/for-clinicians/anxiety*

- Develop a ***hierarchy or step ladder*** – rank the objects, activities or situations from least anxiety-provoking to most anxiety-provoking by using the SUDS rating scale.
- Plan exposure tasks to address the least anxiety-provoking situations first – it is important to attempt to set the client up to begin with an achievable task. This can improve compliance and motivation. For example, a client with a needle phobia may begin exposure tasks by looking at a picture of a needle, rather than commencing with exposure to the physical needle itself.
- Carry out exposure tasks – ensure your client stays in the situation until the anxiety reduces by approximately 50%, because this is one indication that they have successfully challenged their anxious thoughts and beliefs. If possible, it is useful to engage in some exposure tasks with the support of a clinician initially. Additional exposure exercises can then be tasked as homework. The clinician can prompt the client to comment on what they are noticing or what is surprising to them during the exposure task (e.g., that their fear is not actually coming true). The aim of this is to increase the client's external focus (rather than self-focus), awareness of the benign objective outcomes, and to help consolidate the new learning.
- Before progressing to the next step, repeat exposure tasks until anxiety has reduced to a manageable level. Successful exposure tasks should result in the client no longer feeling the need to avoid the previously feared stimuli as they now believe that their fear is unlikely to occur, it is not the catastrophe they expected even if it does occur, and/or that they can cope.
- Evaluate exposure tasks following completion to determine if feared predictions were true or not.
- The clinician may wish to consider incorporating relaxation strategies with the client to engage within exposure tasks, but if the exposure is pitched at the right level this may not be necessary.

Case Example – In Vivo Exposure – Tony

In vivo exposure links directly to the behaviours and thoughts components of the Hot Cross Bun model, because the client has to change their behaviours (e.g., reduce avoidance, approach feared situations) to directly test their thoughts. It can help the client to develop more realistic thoughts about a feared object or situation.

In the case of Tony, who was experiencing panic symptoms, he could benefit from in vivo exposure as he mentioned being fearful and avoidant of several situations. The exposure could involve him resuming running with his dog or drinking a cup of coffee, depending on where in the hierarchy treatment starts and the level of support the clinician will provide. Drinking a cup of coffee would be easily accommodated during a treatment session. After introducing Tony to the concept of SUDS and providing psychoeducation about ***situational exposure***, Tony could be encouraged to keep a ***situational exposure diary***[9]. The clinician and Tony can then use this record to explore what thoughts were going through Tony's mind before the exposure and during the exposure, and examine Tony's expected outcome of the exposure as opposed to what actually happened. While continual avoidance of an object or situation reinforces the fear, exposure is a tool for disconfirming fears.

The Centre for Clinical Interventions also offers the ***Panic Stations workbook***, which is specifically designed to target panic attacks.

Interoceptive Exposure.

Interoceptive exposure is another strategy aimed at confronting feared physiological symptoms by deliberately bringing on such sensations. This is often useful in the treatment of panic, whereby the client begins to associate danger with the physiological symptoms of anxiety (e.g., racing heart, sweating, increased breathing rate). For example, a client who fears experiencing a panic attack may begin to avoid anything that produces an increase in heart rate (e.g., exercise, sexual activity, caffeine intake). Interoceptive exposure exercises (e.g., star jumps or running on the spot to increase the client's heart rate) may assist the client in learning that this physiological response is not dangerous.

9 *Exposure resources available from www.cci.health.wa.gov.au/resources/for-clinicians/anxiety*

Case Example – Interoceptive Exposure – Marie

Interoceptive exposure links to the thoughts and body sensations components of the Hot Cross Bun model. It can help the client to develop more realistic thoughts about a feared sensation.

In the case of Marie, who was very fearful of experiencing further panic attacks, some psychoeducation about ***what panic attacks*** are and ***how they are maintained*** should be provided prior to engaging in any exposure tasks. ***Interoceptive exposure*** would then provide Marie with experiential evidence that panic attacks are not harmful, helping her to learn how to reinterpret the attacks she experiences. Part of her homework could be to keep a record of her ***internal sensations exposure***[10].

The Centre for Clinical Interventions also offers the ***Panic Stations workbook***, which is specifically designed to target panic attacks.

Case Example – Behavioural Experiments – Katie

Behavioural experiments link directly to the thoughts components of the Hot Cross Bun model. They can help the client to test their existing thoughts and beliefs, and to create more adaptive thoughts and beliefs.

In the case of Katie, who was experiencing social anxiety, behavioural experiments could be incorporated into her treatment plan to target her thoughts about other people noticing her body sensations of shaking. Her behavioural experiment could involve deliberately shaking while talking to someone she doesn't know. The aim of these experiments is to identify discrepancies between expected outcomes and actual outcomes. Katie expects that her shaking will be noticeable by others, but the experiment may show her that either 1) the other person did not notice her shaking or 2) that she can tolerate the experience even if they do notice it.

Along with psychoeducation about ***behavioural experiments***, Katie could complete the ***Core Beliefs*** module of ***Stepping Out of Social Anxiety***[11], which includes a worksheet to design and complete the experiment(s).

The Centre for Clinical Interventions has a helpful demonstration video designed for clinicians who are ***developing a behavioural experiment.***[12]

10 Panic resources available from www.cci.health.wa.gov.au/resources/Looking-After-Yourself/Panic

11 Social anxiety resources available from www.cci.health.wa.gov.au/Resources/For-Clinicians/Social-Anxiety

12 The Centre for Clinical Interventions YouTube channel can be found at youtube.com/c/CentreforClinicalInterventions

Table 3.2 Examples of Safety Behaviours and Their Impact on Maintaining Clinical Problems

Clinical Problem	Safety Behaviours	Function of the Safety Behaviour	Outcome of the Safety Behaviour
Depression	Increased alcohol use.	The client can avoid emotional discomfort associated with their depressive symptoms.	The client is not able to learn how to manage their mood in a healthy way.
Generalised Anxiety	Calls family members to ensure they are okay.	The client feels safer as they now do not have to worry about something bad having happened to that family member.	In the moment, the client feels less discomfort because they have confirmed their family member is safe. However, long-term, the client's anxiety is reinforced as they are not learning how to tolerate uncertainty.
Social Anxiety	Having a friend enter a social event with you.	The client feels safer as they have a support person and are therefore not as focused on their perception that everyone at the event is looking at them as they enter.	Although the client feels safer in the immediate situation, long-term their anxiety is reinforced as they have not learned that they can tolerate the discomfort of walking into an event alone, even if everyone is looking at them.
Panic	Scanning a room for exits, and then remaining close to an exit at all times.	The client feels safer, because in the event of a panic attack, they have a quick escape from the room they are in.	Although the client feels safer in the immediate situation, long-term their anxiety is reinforced as they are not able to learn that they can tolerate being away from an exit without experiencing panic.
Phobia – Needles	Asks the medical professional to use a specific type of needle and in a specific area of the body.	The client feels as though they have more control over the situation and that they are avoiding what they perceive as more uncomfortable sensations.	Although the client feels they have retained some control over the situation, their panic is reinforced as there is no opportunity to learn that they can tolerate the discomfort of the procedure regardless of how it is performed.
Health Anxiety	Has people who enter their home wash their shoes in disinfectant.	The client feels safer as they are controlling a potential contaminant entering their home.	The client has reduced their immediate anxiety, but has not learned that they can be safe without controlling all contagions or germs around them.

Sleep Hygiene

Sleep hygiene refers to having a healthy sleep routine. This includes things such as going to bed at a regular time, going to bed when you are sleepy, and ensuring your sleeping environment is optimal. Sleep hygiene is often negatively impacted as a result of mental health symptoms, such as those of depression and anxiety. This is depicted in the case examples of Dave (napping on the couch and not sleeping at night) and Janet (lying awake late at night worrying and then feeling exhausted the following day). Sleep hygiene is an excellent add-on to treatment for any client who is experiencing poor quality sleep, and can easily be provided as self-help materials. The Centre for Clinical Interventions provides a range of *psychoeducation* handouts as well as a *sleep diary* that can be shared with clients. By keeping a record of their sleep, clients can be encouraged to identify patterns and possible problems related to their sleep habits, and then to work on improving them.

Problem-Solving

Problem-solving involves teaching the client a set of skills that helps them to draw on effective strategies to solve problems, rather than worry. Unlike worry, which predominately focuses on the negative possible outcomes, problem-solving is a flexible approach that encourages the client to examine the negatives and positives of a possible solution. Problem-solving is a useful skill to include in treatment for depression and anxiety symptoms, and may be useful if other techniques (e.g., thought diaries, behavioural activation) reveal that there are problems in the client's life that need solving. The Centre for Clinical Interventions offers *psychoeducation materials* about the difference between worry and problem-solving as part of the *What? Me Worry!?!* workbook. They also have a *problem-solving worksheet* available.

Example: Individual LIPI Assessment, Formulation and Treatment Plan

The following illustrates how to complete the Individual LIPI Formulation and Treatment Plan (Handout 2.2) provided in this manual; the blank template is included as Appendix D. The case example used relates to Janet, a 50-year old school teacher who presented to her GP due to concerns about increasing irritability. See Chapter 2 for a brief extract of dialogue between Janet and the clinician, and her Hot Cross Bun formulation. Links to client handouts and psychoeducation materials have been provided throughout the case example. All of these sources can be found on the *Centre for Clinical Interventions* website[13].

13 *cci.health.wa.gov.au/resources/for-clinicians*

Handout 2.2 Case Example

Individual LIPI Formulation and Treatment Plan – Case Example

The clinical problem(s) to be treated

1. Persistent worry (Generalised Anxiety Disorder)
2. Mood disturbance
3. Sleeping difficulties

Problem statement: In Janet's words

I worry about bad things happening. To prevent bad things from happening, I try to think of all the possible outcomes that could happen, especially all the negative outcomes. This makes me worry more about bad things that could happen. As a result, I constantly check up on my family and avoid situations that could result in something bad. I sleep poorly because I can't stop the worrying thoughts. As a result, I feel tired and tense most of the time, and often feel teary or grumpy.

Problem formulation

Use case formulation handout (Hot Cross Bun Model) to complete this section.

Thoughts	What if I'm a bad teacher, I get sick and I lose my job, interest goes up, we lose the house, something happened to my kids, my husband's mine collapses?
Behaviours	Checking up on family, avoid anxiety-provoking situations, pre-empt any negative outcomes
Emotions	Anxious, grumpy, snappy, teary
Body sensations	Tension, headaches, jaw and tooth aches, sleep problems, fatigue, fidgety

Formulation

By trying to manage her worry through pre-empting all possible outcomes to a situation, especially negative outcomes, Janet's anxiety is maintained as she feels this prevents bad things from happening. Janet is negatively reinforcing her worry behaviour by trying to avoid situations that provoke her worry, such as allowing her daughter to drive without her. Janet tends to worry late into the evening when she goes to bed, which causes her sleep to be disrupted and for her to feel fatigued throughout the daytime. This results in her feeling emotionally teary and grumpy, and physically tense.

Identify specific treatment goals

1. Cognitive restructuring	to improve Janet's ability to identify, dispute, and re-frame negative thoughts
2. Problem solving	to help Janet develop healthy ways to manage life stressors
3. De-arousal	to decrease physical tension and improve sleep quality

Identify the most appropriate LIPI modality

Consider client preference and available resources. Tick all that apply.

☒ Self-help: written
☒ Self-help: online
☐ Guided self-help: telephone
☐ Guided self-help: video-conferencing
☒ Face-to-Face individual (number of sessions 5)
☐ Face-to-face group (number of sessions ____)
☐ High intensity treatment is indicated (provide details):

Plan intervention

What resources are available within your service and what additional resources may be needed (e.g., psychoeducation materials, handouts, online resources; see Chapter 3 and Appendix B).

List helpful resources for intervention (hard copy, online)

- Handouts and psychoeducation from the Centre for Clinical Interventions' (CCI) website
- Use materials from CCI's workbook *What? Me Worry!?!*

Based on case formulation and treatment goals, which strategies are indicated:

- CBT formulation and psychoeducation
- Thought challenging
- Mindfulness and attention training
- Behavioural experiments and postponing worry
- Active coping (structured problem-solving)

Treatment session plan

Provide a brief description of what each treatment session will involve:

Session 1
Explain the CBT formulation, and provide psychoeducation about *generalised anxiety and worry*. Introduce the de-arousal technique of *progressive muscle relaxation* (applied relaxation). Plan to practice these techniques to improve sleep and reduce body sensations of tension and aches.

Session 2
Review sleep patterns and use of de-arousal techniques. Introduce challenging beliefs about worry (*positive*, *controllability*). Plan to practice *postponing the worry*, as well as continuing with progressive muscle relaxation.

Session 3
Review practicing postponing worry and troubleshoot any difficulties with the task. Introduce and teach *mindfulness* and *attention training*. Plan to complete the attention training diary as homework.

Session 4
Review completion of the attention training diary. Troubleshoot any difficulties with the task. Introduce active coping, and teach *problem-solving* and *accepting uncertainty*. Continue to practice the strategies that have been taught.

Session 5
Review progress with strategies and discuss relapse prevention. Encourage ongoing commitment to the strategies. Consider planning a 1-month follow-up session.

Outcome Monitoring

What measures will be used to monitor treatment targets?
GAD-7

How often will the measures be administered? (e.g., baseline and every session)
At the initial assessment and in the waiting room before every session

What would indicate treatment has been successful?
Janet would report that she is worrying less and is able to fall asleep within an appropriate amount of time at night. She would also report experiencing less bodily tension and aches, and feeling less irritable. Janet would also report feeling more confident in managing her own mental health in the future using the strategies she has learned during treatment.

Referral to other services?

☒ Not currently required

☐ Required (provide details)

☐ May be required (to be determined following the LIPI)
Consider referral to higher intensity services if symptoms persist or worsen after treatment.

Summary

All LIPIs start with an assessment and personalised formulation of the client's specific problem(s). Once the client's suitability for the service and use of a LIPI has been established, the clinician can start to design a treatment plan that aligns with the client's goals and treatment preferences. Using the Hot Cross Bun model to identify key thoughts, feelings, body sensations, and behaviours, treatment strategies can be purposefully aligned to the client's needs. Each session with the client should have a clear aim and relevant homework tasks that link logically to the client's Hot Cross Bun formulation. This chapter provided clinicians with an introduction to a number of psychological tools and techniques that can be implemented in a LIPI. Further resources can be found at the *Centre for Clinical Interventions* website.

Chapter 4
Delivering LIPIs in Groups

This chapter provides clinicians with the knowledge to create and facilitate groups that are tailored to their clients' needs. Specific considerations for designing a group program and for working therapeutically within the group environment are described. Information on how to access existing manualised group programs and resources is also provided at the end of the chapter.

There are many types and styles of group therapy. The type of group a clinician chooses to develop will depend largely on the issue(s) of concern, the population with which they are working, and the time and resources they have available. While a support group would usually be led by someone who has themselves experienced and overcome the problem of the group focus, an interpersonal therapy group would be led by a qualified mental health professional. Process-oriented groups are concerned primarily with interactions and emotional experiences that occur between members of the group, with clinicians acting as a facilitator to group discussions. These types of groups may be less structured, with the group discussion dictating the course of the session under the guidance of the clinician. Due to their less structured and more time-consuming nature, process-oriented groups would not typically be considered a LIPI.

Psychoeducational groups generally focus on imparting information about a particular issue and teaching coping and problem-solving skills to group members, with the clinician assuming more of an instructor or teacher type role. These groups are well suited to LIPIs because they tend to be focused, skills-based, and structured within sessions and week to week.

Research indicates that group therapy is an effective treatment option (American Group Therapy Association, AGPA, 2007). While individual therapy relies on the interactions that take place between only the client and the clinician, group therapy is the result of a complex combination of interactions between the client, the clinician, and the other group members. It includes interactions the client experiences personally and those they witness between other members (MacKenzie, 1997). This environment can be very powerful, as it provides group members the opportunity to see others benefiting from implementing the techniques. This can enhance engagement, increase motivation, and reinforce the treatment principles.

This chapter is divided into two parts. The first part lists eight considerations that will help clinicians to create a successful group LIPI. When designing and planning a group LIPI, clinicians might find it helpful to complete the Group LIPI Design and Session Plan (Handout 4.1 – Appendix F), a completed example of which has been included in this chapter. The second part of this chapter discusses factors that should be considered once the group program has been established.

Designing the Group

Identify the Problem

Developing and facilitating an effective therapy group starts with good planning. Groups that target different problems and different populations will have varying structures and goals (DeAngelis, 2018). Groups do not need to be limited to a single problem or issue. For example, Norton (2012) describes the construction of a transdiagnostic anxiety group as being based on each member of the group having a fear of something, rather than sharing the same specific fear or diagnosis. In this way, the aim of the group program is to target excessive fear more broadly, as opposed to specific types of fears. LIPIs should be problem-oriented as they are intended to provide brief, time-limited support. Therefore, groups aimed at addressing chronic and pervasive personality pathology or interpersonal processes over a protracted period of time are not considered LIPIs. Much like individually delivered LIPIs, a particular clinical problem may not necessarily preclude participation in a group LIPI. A group program could be designed to target specific aspects of a client's problems. This may be beneficial for clients who are waitlisted for higher intensity services or where such services are not currently accessible.

Examples of problems suitable for group therapy:

- Anxiety, depression, and other mental health disorders
- Community specific problems (e.g., stress related to drought, bushfire, or unemployment)
- Daily and lifestyle stresses
- Medical conditions
- Bereavement / grief
- Loneliness
- Weight loss and healthy nutrition
- Domestic violence
- Divorce and relationship conflict
- Parenting
- Bullying
- Anger management
- Addiction
- Sleep problems
- Healthy lifestyle factors, such as diet, exercise, and smoking cessation

Once the problem focus of the group has been identified, the clinician needs to decide whether the sessions will be guided by an open discussion format or a more structured format. Sessions could be organised around topics, activities, a combination of both (Whitaker, 2005), or an existing manualised treatment program. It can be helpful to think about who is being treated, what benefit clients get out of participating in the group, and how this will be achieved within each session. The population being treated could be categorised in a number of ways, for example, by problem type (e.g., anxiety, depression, stress), by life stage (e.g., adolescent, adult, older adult), or by community-specific issue (e.g., drought, bushfires). The desired outcomes from participating in the group can also vary. For example, the aim may to develop better interpersonal skills, improved coping skills, or to relieve symptoms of depression or anxiety. For groups in which participants may have more chronic mental health needs, the aim of the program may be to prevent further psychological deterioration by targeting distinct problems, such as sleeping patterns.

Session Time and Length

When deciding the group schedule, it is important to consider the clients' needs, such as when they are most likely to be able to attend. For example, you might not want to run a group designed for parents around school start or end times, as parents are likely to be attending school. Finding out when clients are available can be asked in the assessment interview. The length of the sessions will be determined by the amount of content the clinician plans to cover. If the group is purely psychoeducation, whereby the clinician is didactically imparting information, the sessions will be shorter than more interactive, skills-based groups. For skills-based therapeutic groups, there needs to be sufficient time to review homework from the previous session, introduce and practice a new skill, and then set new homework tasks for the coming week.

Session Frequency

The frequency of group sessions is designed to suit the service and clients. In many instances, weekly group sessions minimise the time imposition on clients and clinicians, allowing sufficient time between sessions for clients to practice their new skills, and allowing the clinician to observe clients' progress over a period of time. Another option includes blocking an intervention within a single day or week, with a possible follow-up session to monitor progress (e.g., 2 weeks or 1 month later).

Number of Sessions

Groups can be conducted in an open or closed format. Open groups run continuously and allow members to join at any point. Open groups are therefore flexible and compositionally diverse, as some members will be further along in their group therapy journey. This can be particularly beneficial modelling for new members. Drop-outs are less likely to impact the open group, as new members quickly take their space in the group. Also, termination anxiety may be reduced given that members are exposed to people coming and going from the group at various times.

A closed group has set commencement and completion dates and a designated number of planned sessions. The group members all start and end the program at the same time. This type of group requires careful planning (MacKenzie, 1997) and each session usually covers a predetermined topic or issue. The number of sessions will depend on the target problem, the available resources, and the type of program the clinician chooses to run. It may be helpful to remember that LIPI is a targeted, problem-solving, and time-limited approach when deciding on the number of sessions.

Recruiting Participants

Recruitment is a vital aspect to consider when designing a group program as an adequate number of participants is essential for it to be successful (DeAngelis, 2018). Participants may be recruited through a variety of means. Clinicians may identify clients from their existing case load or those on their waitlist who would benefit from group therapy (DeAngelis, 2018). The clinician may notice that a certain problem or population appears frequently in their referral list, and therefore decide to create a group program targeting this issue. Once the program has been established, the service may receive more referrals for the group-based LIPI, particularly if information explaining the group program (including inclusion and exclusion criteria) has been disseminated to referrers, such as GPs.

Location and Room Set-Up

Consideration will need to be given to where the group will meet. A group might be held at a mental health agency or hospital, a community centre, a retirement village, or library. The location should be central, and accessible in terms of public transport and parking, and for people with physical disabilities. The set-up of the room depends on the nature of the group. If the group is dedicated to imparting psychoeducational information and is delivered in a presentational style, then a theatre set up in which the audience face the stage in rows would be appropriate. However, if the group will involve discussions and disclosure, then the set up should have the chairs arranged in a circle so that each member can comfortably interact face-to-face with each other. The clinician would also need to ensure that the room is secure and free of interruptions during the session.

Selecting Participants

Individual client success, as well as the success of the overall group, is heavily contingent upon appropriate client selection. This is especially true for LIPIs given their time-limited, problem-specific nature (Yalom & Leszcz, 2005). Client selection involves screening for clients who are likely to benefit from group therapy (individual suitability) and then creating a mix of clients that can bring different benefits to the group (group composition) (AGPA, 2007). It is common for clinicians to select participants for groups on the basis of exclusion rather than inclusion criteria. This deselection process applies only to the specific group being recruited at that time, rather than any and all groups (Yalom & Leszcz, 2005). That is, the characteristic that makes a client unsuitable for one group (e.g., co-occurring substance addiction) may be the same characteristic that makes them eligible for another group (e.g., substance addiction group therapy).

Group Selection Case Examples

Michael is a 28-year old man who was referred by his GP for depression. Assessment has indicated that he has antisocial traits and some difficulty in managing his anger. He is not a good candidate for a group program in which the overall treatment target is depression. However, Michael is a good candidate for a group program designed specifically for individuals with anger problems.

Jean is a 62-year-old married mother of two who reports having difficulties sleeping. During her assessment, Jean reported that she has no more than one or two glasses of alcohol per night and she only occasionally uses sleep medication. Jean was personable, open about her issues, and reported that she felt she was the only person experiencing sleep problems. Jean was very open to meeting other people with similar problems and was keen to learn practical skills so that she could experience more refreshing sleep without relying on alcohol and medication. Jean is an excellent candidate for group therapy.

David is a 17-year-old male with social anxiety and low self-esteem. He tends to avoid social situations if he can and has few friends, but he is able to function at work. David feels isolated and was surprised to hear that other people also experience anxiety like him. David doesn't really understand why he feels so anxious in some social situations, which he finds very frustrating. He knows he needs to make some changes and would like to learn some skills to build his confidence when having conversations with others. David finds the physical symptoms of anxiety very uncomfortable and distracting, and would like to be able to manage these symptoms better. The clinician plans to run an anxiety management group and believes David could benefit from learning strategies to manage his anxious thoughts, reduce his avoidance behaviours, reduce his physiological arousal (body sensations), and to start participating in more social situations. David would be a good candidate for group therapy, as it would provide him with a safe context within which to practice his new skills with other group members.

Mel is a 30-year-old mother of a newborn baby who is noticing herself worrying uncontrollably about her baby's and her own health. Mel's baby only sleeps for 1 hour at a time and is unsettled when she is awake. Mel is exhausted, both physically and mentally, and she was late for her assessment appointment. Mel would not be a good candidate for group therapy because she would find it very difficult to commit to attending sessions at a particular time and day. The clinician decides to schedule some individual sessions with Mel, and reassures her that she can reschedule if necessary. The clinician considers designing an open group program for new parents who are struggling with sleep and their mood, which will provide the flexibility clients like Mel require.

Yalom and Leszcz (2005, p. 234) stated that "clients will fail in group therapy if they are unable to participate in the primary task of the group, be it for logistical, intellectual, psychological, or interpersonal reasons". Their assertion is a useful guide for clinicians when matching clients to the group that best suits their needs. Clients who lack personal insight, or who need active clinical management, may not be suited to LIPIs generally, and the appropriateness of a higher intensity service should be considered depending on the nature of the problem and the client's willingness to engage with the self-help emphasis of a LIPI.

The same characteristics that make a client suitable for an individual LIPI can be applied to selection for group LIPIs. These include some motivation to change, a willingness to contribute actively to their own formulation and treatment plan, and the capacity to be responsible for helping themselves. In addition to these characteristics, clients participating in group LIPIs may need to be willing to make disclosures about themselves and the nature of their problem in front of other group members, to receive constructive feedback as well as provide it to other group members. In groups that are predominantly psychoeducational, this is less important.

Prospective participants must also be willing and able to commit to attending the group regularly. When clients fail to attend or arrive late, it can disrupt the cohesion of the overall group and lessen the value of the treatment. Drop-outs do not only affect their own treatment, but they can also influence the remaining group members (Yalom & Leszcz, 2005), so limiting the likeliness of a client dropping out is helpful for optimising the success of the group. That said, group members typically adjust to people discontinuing. Drop-out cannot be eliminated entirely, however clinicians can take reasonable steps to reduce it. For example, clinicians should ensure the client has a realistic understanding of what participating in the group will involve and that their

goals are aligned with the overall aims of the group. If the client cannot see what benefit they could receive from the group or they lack hope that change is possible, they are unlikely to be engaged with the group and may discontinue their participation. It may be beneficial to first provide some motivational interviewing prior to delivering the group LIPI.

Group Size

The size of a group will depend on a range of factors including the complexity of the target problem, group type, number of available facilitators, number of referrals, room size, and how often the group will run. It may be perfectly reasonable to have a larger number of participants (e.g., 12 or more) in a psychoeducational group where clients are predominantly listening to the clinician, but 6-10 is generally recommended for groups that rely heavily on skills development and practice. In terms of cost and time effectiveness, a larger group can treat more people simultaneously, however self-disclosure, individualised attention and homework review, and interpersonal interaction between the group members will be reduced as the group size increases. When you are deciding on how many participants to include think about the purpose of the group. The number of participants recruited should correspond according to this purpose and the group structure (e.g., psychoeducational only, skills development and practice, or a combination of both).

Consumer and Carer Engagement and Participation

Consumers and carers are people with a lived experience of mental illness and/or suicide and who access or who could potentially access mental health services. Carers are people who provide personal care, support and assistance to another person who has a mental health difficulty, has suicidal ideation, or has attempted suicide. Consumer and carer engagement and participation refers to consumers' and carers' involvement in the planning, delivery, implementation, and evaluation of all activities associated with mental health services. Consumers and carers need to be active partners in co-designing mental health services to ensure optimum outcomes. Services planning to develop group LIPIs should strive to include the consumer and carer voice in the co-design of all aspects of the program. Service managers can consult with consumer and carer advocates within the service to facilitate co-design. See the ***PHN guidance document on consumer and carer engagement and participation*** for more information.

Example Group LIPI Session Planning

Existing Manualised Groups

The ***Centre for Clinical Interventions*** offers several group program outlines for common psychological problems including anxiety and depression (***Mood Management Course***) and worry and rumination (***Working with Worry and Rumination***). A number of manual outlines for ***other problems*** are also freely available.

Example Group LIPI Design and Session Planning

The following illustrates how to complete the Group LIPI Design and Session Plan (Handout 4.1) provided in this manual; the blank template is included in Appendix F. Background information is provided first, followed by a completed handout. Links to client handouts and psychoeducation materials have been provided throughout the case example. All of these sources can be found on the ***Centre for Clinical Interventions*** website.[14]

Background information.

Clinicians at a local mental health service have noticed an increase in referrals for depression in the context of difficult economic times for the community, and the waitlist is getting long. Sue is the service manager and she uses Handout 4.1 (see Appendix F) to help her design a LIPI that meets the needs of her community with the resources she has available.

Sue is aware of online materials that will suit some of her clients, so she decides to provide all new referrals with a handout detailing online treatments that have proven to be effective for depression (e.g., ***ports.org.au***; ***www.cci.health.wa.gov.au***) along with crisis services (e.g., ***lifeline***). While they are on the waitlist, clients will be encouraged to view these materials and see if they find them helpful. It might be that some clients would benefit from seeing a clinician for a single appointment to guide them towards specific programs that might be helpful for them. Alternatively, two or three additional sessions might be offered to guide clients through the online materials so that they get the most out of them.

Sue knows that some clients would much prefer to see a mental health worker face-to-face rather than

14 *cci.health.wa.gov.au/resources/for-clinicians*

use online materials, so she considers the options for other LIPIs. Group work would provide clients with the opportunity to receive face-to-face services and would also help them to receive support from other group members. The service would save resources by being able to provide services to multiple clients at once. Sue decides to design a group program using strategies that have been shown to be effective. Sleep hygiene, behavioural activation (pleasant activity scheduling), active coping (structured problem-solving), and thought challenging are selected as strategies that Sue believes will help people to find potential solutions to their problems, become physically and behaviourally activated, and help them to challenge negative thinking. Sue plans to invite 10 to 15 people with depression to attend a 5-week group program that she will co-facilitate with another mental health worker within the service. Clients who prefer individual treatment will be encouraged to try group therapy first, but they can receive a limited number of focused individual sessions if they do not seem suitable for the group or if they have a strong preference for individual treatment.

Clinicians will use the Kessler 10 (K10) to measure changes in distress for each client so that Sue can determine how many people are benefiting from the group LIPI. The care pathway might need to be adapted over time to continually improve client outcomes.

Handout 4.1 Case Example

Group LIPI Design and Session Plan – Case Example

The clinical problem(s) to be treated

1. Depression in the context of economic difficulties in the town

Problem statement
Many clients are presenting with depression as a consequence of the economic downturn in the community. There are common patterns of withdrawal and isolation, hopelessness and helplessness, and depression and anxiety symptoms.

Problem formulation

Use case formulation handout: Hot Cross Bun Model

Thoughts	hopelessness about the future, helpless
Behaviours	isolation and withdrawal from community activities leading to lack of social supports, drinking and drug-taking behaviour, excessive sleeping in the daytime
Body sensations	fatigue, lack of energy, insomnia
Emotions	sadness, depression, anxiety, worry

Formulation
Thoughts of hopelessness and helplessness about the future lead to isolation and substance use, which reduces social support, engagement in previously enjoyed activities, and active problem-solving. This, in turn, exacerbates fatigue, lack of energy, and excessive sleeping, causing insomnia at night. Thoughts and behaviours lead to sadness, depression, and anxiety and worry about the future.

Session details

Provide details on session length, time and day, and frequency, and total number of sessions.

Session length (e.g., 30mins, 60 mins)	60 minutes
Session time and day	6pm on Monday evenings
Session frequency (e.g., weekly, fortnightly)	weekly
Number of sessions (e.g., 6 sessions, 10 sessions)	5

Location details

Consider where the group will be held and a room set-up that is appropriate for the group purpose.

Location of group (e.g., within the clinic, at a medical centre, town library)
Town community centre function room

Does this location have adequate:
☒ Parking
☒ Public transport
☒ Accessibility

Room set-up and required materials (e.g., whiteboard, chairs, etc)
Whiteboard and markers, chairs, psychoeducational materials to handout, pens

Recruitment details

How will clients be recruited to the program? Tick all that apply.
☒ Internal client referral
☒ External client referral (e.g., GPs, other services)
☒ Promotional materials distributed to medical clinic waiting rooms etc
☒ Other (provide details)

How many participants will be recruited to the group?
10-15

Identify specific treatment goals	
1. Behavioural activation	to increase engagement in previously enjoyed activities and to increase social supports
2. Active coping	learn how to identify and plan for solutions to problems
3. Sleep hygiene	learn how to maintain a regular sleep-wake cycle
4. Thought challenging	learn how to identify and challenge unhelpful thoughts

Identify the most appropriate LIPI modality

Consider client preference and available resources. Tick all that apply.

☐ Self-help: written, online

☐ Guided self-help telephone

☐ Guided self-help video-conferencing

☒ Guided self-help online

☐ Face-to-Face individual (Number of sessions____)

☒ Face-to-face group (Number of sessions: 5 weekly sessions, 2 hours each)

☐ High intensity treatment is indicated: _____

All clients will be directed to use PORTs (if eligible) or Mindspot.org.au (if ineligible for PORTs) until the group treatment can commence.

Plan intervention

Determine what services are available within your workplace, and link to additional resources if needed (e.g., psychoeducation materials, handouts, online resources, see Chapter 3

List helpful resources for intervention (hard copy, online)

- Handouts and psychoeducation from the Centre for Clinical Interventions' website

Based on case formulation and treatment goals, which strategies are indicated:

- CBT formulation
- Sleep hygiene
- Behavioural monitoring and activation
- Active coping (structured problem-solving)
- Thought challenging

Treatment session plan

Provide a brief description of what each treatment session will involve:

Session 1
Ice breaker, learn about the CBT formulation, provide *sleep hygiene* psychoeducation. Provide *psychoeducation material on sleep* and plan to implement a healthy sleep routine for homework.

Session 2
Review sleep patterns. Introduce *behavioural activation* (use *Back from the Bluez*, from the Centre for Clinical Intervention website). Plan to maintain healthy sleep routine and to complete a behavioural activation task for homework.

Session 3
Review sleep routine and behavioural activation homework. Plan activities for the coming week. Teach active coping (structured problem-solving) based on *What? Me Worry!?!*). Clients practice active coping in the group in relation to a problem they are currently dealing with. Homework is to complete a pleasant activity and to try one of their potential solutions to their problem.

Session 4
Review progress to date and continue with sleep routine, behavioural activation, and active coping. Troubleshoot any difficulties. Use *Back from the Bluez* to introduce thought-challenging.

Session 5
Review progress with strategies and discuss relapse prevention. Review progress and encourage ongoing commitment to the strategies. Consider planning a 1-month follow-up session.

Outcome monitoring

What measures will be used to monitor treatment targets?
Kessler 10

How often will the measures be administered? (e.g., baseline and every session)
At the initial assessment and in the waiting room before every session

What would indicate treatment has been successful?
Clients reporting that their symptoms have reduced and that they have learned some skills that will help them manage their mental health in the future.

Referral to other services?

☐ Not currently required

☐ Required (provide details)

☒ May be required (to be determined following the LIPI)
Consider referral to higher intensity services if symptoms persist or worsen after group treatment.

Conducting the Group

Intake Assessment and Case Formulation

As for individual treatment, group therapy starts with an individual intake assessment that includes development of a case formulation with the client. The client's presenting problem and goals for coming to treatment should be clearly articulated. Screening and assessment is an opportunity to prioritise the client's needs. For example, Bennett-Levy et al. (2010) suggest that clients experiencing co-occurring substance abuse issues should be first referred for treatment targeting this problem prior to participating in a LIPI group. Any questions or worries the client has about participating in group therapy should be fully explored and resolved. The clinician should explain to potential group members the benefits and effectiveness of group therapy. Outcome measures can be implemented to assess suitability for the group and to assess change once accepted into the group (Bennett-Levy et al., 2010). Chapter 2 provides detailed guidance on conducting an assessment and using outcome measures. A Quick Guide to LIPI Assessment has also been provided as Appendix E.

Therapeutic Engagement

The therapeutic alliance is pivotal to successful group therapy. It is important that clinicians take the time to foster a non-judgmental and open space in which group members can feel safe and secure. This is especially important in the first couple of sessions, during which it is best to limit challenging or confrontational exchanges. Group therapy differs from individual therapy in that there are multiple dyadic relationships and group level processes that take place (DeAngelis, 2018). However, it is important to note that within the context of a time-limited LIPI, the focus is typically on psychoeducation and skills development rather than group process.

Group Cohesion

Group cohesion refers to the extent that each group member is interested and engaged with each other group member (White & Freeman, 2000) and this will be influenced by the mix of relational styles present among the group members (Bennett-Levy, 2010). Although LIPI group therapy is not specifically focused on working with complex process factors, clients' relational styles will have an effect on the way in which a group operates. Therefore, relational styles should be considered during the participant selection phase of setting up the group. One of the clinician's primary functions is to develop and foster a strong group cohesiveness, as this will ensure the integrity of the group remains robust even when disagreements and challenges arise between members (White & Freeman, 2000). As an example, it may not be appropriate to include an individual who has difficulty regulating strong emotion or an inability to inhibit their reactions to others, if that client's relational style will negatively impact the progress of the other group members.

Adherence to treatment and drop-out are common problems for clinicians running group programs. Clients can sometimes express a sincere desire to engage with treatment during and after the initial assessment, but motivation is multidimensional (we can be more motivated to change some things more than others) and it can wax and wane over time. Integrating motivational interviewing throughout the group sessions when required may therefore be helpful for maintaining client engagement and momentum (Norton, 2012). It is essential that your clients understand that change is a process as opposed to a binary outcome, and that it is normal to feel ambivalent about changing, even when they do want to change (Norton, 2012). If clients appear disengaged or express ambivalence towards change during sessions, it can be helpful for clinicians to guide clients through an exercise that has them identify discrepancies between their values, current behaviours, and desired behaviours, while fostering hope that change is possible (Norton, 2012). Chapter 3 provides more information about incorporating this and motivational interviewing into a treatment plan.

Introductions

The first session involves creating a non-judgmental and safe space for the group members, as well as reiterating the group rules. Introductions may cause distress for some people experiencing anxiety. The clinician can model the introductions for the group by telling them who they are, what their background is, and something about themselves that is both personal and appropriately benign (Norton, 2012). For example, information to share with the group could be enjoying baking on the weekend or spending time with a pet. The clinician should also let the group know that what and how much they share is up to each individual so that self-disclosure is introduced in a safe way.

Example clinician introduction:
"Welcome everyone. My name is Sarah and I am a Community Mental Health Nurse. I've been working here for several years, both running groups and working individually with clients. I'd like to get to know you each a little better, and for each of you to get to know each other too. Let's go around the room and each tell the group your name, why you've chosen to be part of this group, and something about yourself that is totally unrelated to the group. You can share as much or as little as you want to. It is up to you. I'll get us started. On my weekends off I like to get out in the sun and play a round of golf."

Group Rules and Confidentiality

Group rules should be addressed in the first session before the group begins therapeutic work. Clinicians must ensure adequate discussion of the limits of confidentiality. Not only is this an ethical and legal issue, but the members of the group also need to know that they can make disclosures in a safe environment, and this initial open discussion can foster a therapeutic bond with the group. The importance of regular and punctual attendance, homework completion, (Norton, 2012), active and equal participation, and the need to not attend under the influence of substances (e.g., drugs or alcohol), also need to be discussed. Group members can also be invited to suggest rules that they wish to abide for the duration of the group.

Example of a clinician reiterating group rules:
"Before we get into our first session, I'd like to go over the rules of the group again. We will be meeting over the next [insert number] weeks for [insert hours] per session. It's really important that everyone attends the sessions and that you arrive on time, as being late can be disruptive and you might miss important information. It is also important to participate as much as you can in the group, and that everyone has equal opportunity participate, as this gives you the best chance of receiving effective treatment. Completing homework is important for you to get the most out of treatment. We also need to discuss confidentiality. Everything you say in this group is between yourself and the group. You may talk to your friends and family about your experience of the group as it relates to you if you wish, but it is important that everyone agrees not to disclose anything about other group members. Does anyone have any questions about our group rules?"

Tracking Group Outcome Measure Scores

The following example demonstrates how a clinician could use the PHQ-9 to track the progress of clients in a depression group throughout the duration of their treatment.

Case Example – Outcome Measure – Depression Group

The clinicians running the group decided the PHQ-9 would be helpful for tracking depression symptoms for each client. Clients completed the PHQ-9 during the initial assessment (baseline) and in the waiting room before each of the six treatment sessions. The clinicians graphed each client's scores after each session so that it was clear who was responding well and who was not. The clinicians debriefed after each group session and used the graph to plan the next session (e.g., if a particular client's scores were not improving the clinicians tried to understand why this might be the case, and planned how they would provide the client with additional guidance in the next session). Figure 4.1 shows six clients' scores over the duration of the group.

The clinician noticed that clients 1, 3, and 5 had the largest improvements in their depression symptoms, each falling within the mild range (e.g., score of 0-5) by the final group session. These clients were discharged. Client 6 also showed some symptom improvement. Although the improvement was more modest, the clinicians were confident that this client would continue to apply the skills they learned in the group and improve further. On this basis, this client was also discharged.

Client 2 showed some minor improvement in depressive symptoms, but was still just below the moderate range (e.g., score of 10-15) at the end of the group. The clinicians decided to meet with this client to offer alternative treatment options. It was agreed that this client would meet with a clinician for 2-3, 30 minute individual LIPI sessions to reinforce the treatment principles.

Client 4 showed a worsening of depressive symptoms, finishing the group just within the moderate-severe range (e.g., score of 15-20). The clinicians referred this client to a higher intensity service to address additional needs that required specialist intervention.

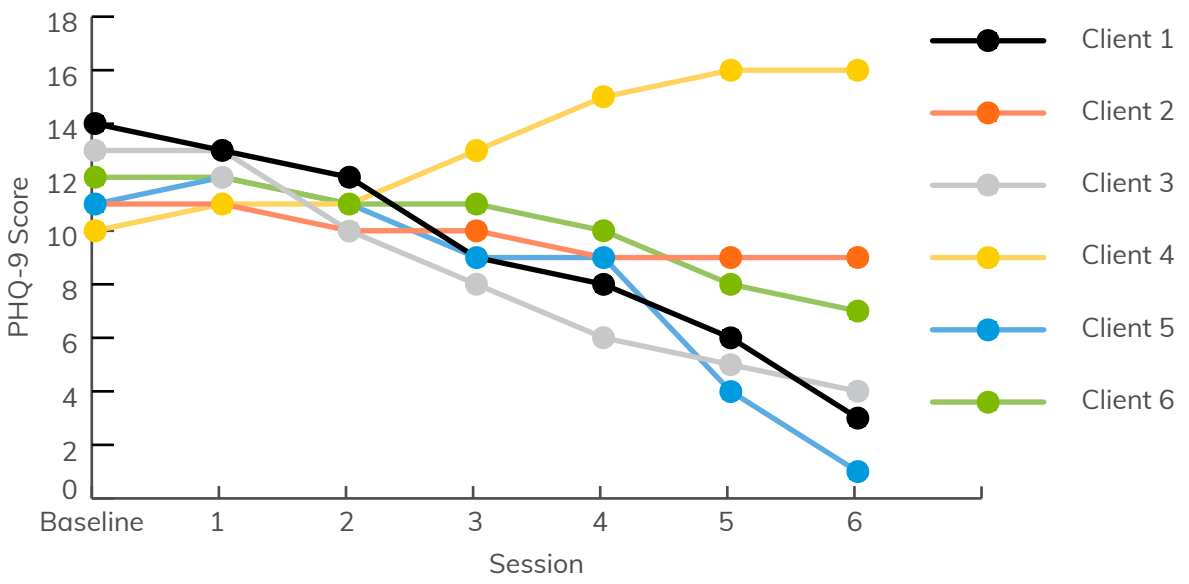

Figure 4.1 *Depression Group PHQ-9 Scores*

Managing Termination

It is important to effectively manage clients' termination from the group. MacKenzie (1997) lists several themes that may arise for clients during the termination phase. These include a sense that more could have or should have been achieved by attending the group, a sense of loss, and a sense of incompleteness. Clients may also be confronted by the reality that they are now responsible for themselves and do not have the active encouragement and guidance of the group to support their journey. Navigating these issues can be daunting, especially for inexperienced clinicians. However, it is important to address any issues that clients have around termination, which can be addressed by setting realistic expectations of the group and discussing termination issues during the last session. Such concerns should not be avoided. Ongoing supervision and training are essential. Given the time-limited nature of LIPIs, these issues may be less likely to arise compared with longer-term and more intensive therapies.

Summary

Conducting LIPI treatment in a group setting can be both an efficient use of time and cost-effective. For certain psychological problems and suitable clients, it can also provide group members with additional skills development beyond what they might receive through individual treatment (e.g., for clients with social anxiety). The type of LIPI group a clinician chooses to deliver will depend largely on the target population, the clinician's experience, and availability of resources. When designing a group LIPI treatment, deliberate consideration should be given to factors such as: recruitment, assessment, and the selection of group members; the number, frequency, and duration of sessions; the time and location of the group; the room set-up; and group size. An assessment should be conducted for all potential group members prior to joining the group, to ensure they will benefit from the purpose of the group and the intervention delivered in a group format.

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Appendix A

Outcome Monitoring Measures

The following table has been adapted from information provided by Beidas, Stewart, Walsh, Lucas, Downey, Jackson, Fernandez, and Mandell, (2015) in their comprehensive review of free, brief, and validated standardised instruments for mental health settings. Additional measures have been added to the table for the purpose of this manual.

ANXIETY AND DEPRESSION						
Measure	**Citation**	**Description**	**Screening**	**Diagnostic**	**Symptom Change**	**Available From**
Depression Anxiety Stress Scales (DASS)	Lovibond & Lovibond (1995)	A 21-item measure of depression, anxiety, and stress in adults.	✔		✔	*http://bit.ly/36lO3O9*
Kessler Psychological Distress Scale (K-10)	Kessler, Andrews, Colpe, Hiripi, Mroczek, Normand, Walters & Zaslavsky (2002)	A 10-item measure of psychological distress in adults.	✔			*https://bit.ly/3a7Y96t*
ANXIETY						
Measure	**Citation**	**Description**	**Screening**	**Diagnostic**	**Symptom Change**	**Available From**
The Clinically Useful Anxiety Outcome Scale (CUXOS)	Zimmerman, Chelminski, Young & Dalrymple (2010)	A 20-item measure of anxiety symptoms in adults.	✔		✔	*https://bit.ly/3oyyg53*
Generalized Anxiety Disorder Screener (GAD-7)	Spitzer, Kroenke, Williams & Löwe (2006)	A 7-item measure of anxiety symptoms in adults.	✔	✔	✔	*http://bit.ly/3iT0QwB*
Hamilton Rating Scale for Anxiety (HAM-A)	Hamilton (1959)	A 14-item measure of anxiety symptoms in adults.	✔		✔	Measure: *https://bit.ly/36jE109* Scoring: *https://bit.ly/3j0HdTl*

ANXIETY						
Measure	Citation	Description	Screening	Diagnostic	Symptom Change	Available From
Liebowitz Social Anxiety Scale Clinician/Self-Report (LSAS-CR/SR)	Cox, Ross, Swinson & Direnfeld (1998) Liebowitz (1987)	A 24-item measure of fear and avoidance of social situations in adults.				*http://bit.ly/2MbxAFp*
Panic Disorder Severity Scale (PDSS)	Shear, Brown, Barlow, Money, Sholomskas, Woods & Papp (1997)	A 7-item measure of panic disorder in adults.	✔	✔	✔	*https://bit.ly/39qG4kR*
Fear Questionnaire (FQ)	Marks & Mathews (1979)	A 24-item measure of blood-injury anxiety, social anxiety, and agoraphobia in adults.			✔	*https://bit.ly/3rjZ36H*
Penn State Worry Questionnaire (PSWQ)	Meyer, Miller, Metzger & Borkovec (1990)	A 16-item measure of worry associated with Generalised Anxiety Disorder (GAD) in adults.	✔		✔	*https://bit.ly/3tqpj1i*
Social Phobia Inventory (SPIN)	Connor, Davidson, Churchill, Sherwood, Foa & Weisler (2000)	A 17-item measure of social phobia symptoms in adults.	✔		✔	*david011@mc.duke.edu* *https://bit.ly/3tdI482*
Mini-SPIN	Connor, Kobak, Churchill, Katzelnick & Davidson (2001)	A 3-item measure of social phobia symptoms in adults.	✔			*david011@mc.duke.edu*
Worry and Anxiety Questionnaire (WAQ)	Dugas, Freeston, Provencher, Lachance, Ladouceur & Gosselin (2001)	An 11-item measure of GAD symptoms in adults.	✔	✔	✔	*https://bit.ly/3t6fbu6*
Health Anxiety Inventory (HAI)	Salkovski, Rimes, Warwick & Clark (2002)	A 14-item measure of symptoms of health anxiety.	✔		✔	*https://bit.ly/3jhfIVM*

ANXIETY						
Measure	Citation	Description	Screening	Diagnostic	Symptom Change	Available From
Obsessive-Compulsive Inventory – Revised (OCI-R)	Foa, Huppert, Leiberg, Langner Kichic, Hajcak, & Salkovski (2002)	An 18-item measure of the severity and type of symptoms of obsessive-compulsive disorder (OCD).	✔			*https://bit.ly/2YlsV6h*
DEPRESSION						
Measure	Citation	Description	Screening	Diagnostic	Symptom Change	Available From
The Clinically Useful Depression Outcome Scale (CUDOS)	Zimmerman, Chelminski, McGlinchey & Posternak, (2008)	An 18-item measure of symptoms of depression.	✔	✔	✔	*https://bit.ly/3qShX4m*
Hamilton Rating Scale for Depression (HAM-D)	Hamilton 1960	A 17-item measure of depressive symptoms in adults.	✔			Measure: *https://bit.ly/3cmzLR9* Scoring: *https://bit.ly/3pqq2gr*
The Inventory of Depressive Symptoms and the Quick Inventory of Depressive Symptoms (IDS and QIDS)	Rush, Giles, Schlesser, Fulton, Weissenburger & Burns (1986) Rush, Gullion, Basco, Jarrett & Trivedi (1996) Rush, Trivedi, Ibrahim, Carmody, Arnow, Klein & Keller (2003)	A 30-item (quick form is 16-items) measure of severity of depressive symptoms.	✔	✔	✔	*http://bit.ly/3cvmu9d*

DEPRESSION						
Measure	Citation	Description	Screening	Diagnostic	Symptom Change	Available From
Patient Health Questionnaire-9 (PHQ-9)	Kroenke, Spitzer & Williams (2001)	A 9-item measure of depressive symptoms in adults.	✔	✔	✔	*http://bit.ly/3iT0QwB*
Edinburgh Postnatal Depression Scale	Cox, Holden & Sagovsky (1987)	A 10-item measure of symptoms of emotional distress during pregnancy and the postnatal period.	✔			*https://bit.ly/3rbv0OL*
EATING DISORDERS						
Measure	Citation	Description	Screening	Diagnostic	Symptom Change	Available From
Eating Disorder Diagnostic Scale (EDDS)	Stice, Telch & Rizvi (2000)	A 22-item measure of symptoms of anorexia nervosa, bulimia nervosa, and binge eating disorder in adults.	✔	✔	✔	Scale: *https://bit.ly/36kkVqC* Scoring: *https://bit.ly/2MaKOSS*
Sick, Control, One, Fat, Food Screening Tool (SCOFF)	Morgan, Reid & Lacey (1999)	A 5-item measure of eating concerns in adults.	✔			*https://bit.ly/3iSyTow*
PANIC						
Measure	Citation	Description	Screening	Diagnostic	Symptom Change	Available From
Panic Disorder Severity Scale (PDSS)	Shear, Brown, Barlow, Money, Sholomskas, Woods, & Gorman, Papp (1997)	A 7-item measure of panic symptoms in adults.	✔	✔	✔	*https://bit.ly/39qG4kR*

SLEEP DISTURBANCE						
Measure	Citation	Description	Screening	Diagnostic	Symptom Change	Available From
Pittsburgh Sleep Quality Index (PSQI)	Buysse, Reynolds, Monk, Berman & Kupfer (1989)	A 24-item measure of sleep quality and disturbance in adults.	✔	✔		*https://bit.ly/2YoXzf7*
SUBSTANCE USE						
Measure	Citation	Description	Screening	Diagnostic	Symptom Change	Available From
Alcohol Use Disorders Identification Test (AUDIT)	Babor, Higgins-Biddle, Saunders & Monteiro (2019)	A 10-item measure to screen for excessive drinking and aid in brief assessment.	✔			*https://bit.ly/3iQxnDy*
SUICIDALITY						
Measure	Citation	Description	Screening	Diagnostic	Symptom Change	Available From
The Suicide Behaviors Questionnaire – Revised (SBQ-R)	Osman, Bagge, Guitierrez, Konick, Kooper & Barrios (2001)	A 4-item measure assessing suicidality in adults.	✔			*https://bit.ly/39nYUZH*
Columbia-Suicide Severity Rating Scale (C-SSRS)	Posner, Brown, Stanley, Brent, Yershova, Oquendo & Mann (2011)	A 20-item measure assessing severity of suicidal behaviour and ideation in adolescents and adults.	✔		✔	*https://bit.ly/3sX1LAG*

OVERALL MENTAL HEALTH						
Measure	Citation	Description	Screening	Diagnostic	Symptom Change	Available From
National Institutes of Health Patient Reported Outcomes Measurement Information System	Health Measures (2019)	A database of measures for monitoring global, physical, mental, and social health symptoms in adults.			✔	*http://bit.ly/3pt7oV7* Requires free registration to access.
Patient Health Questionnaires (PHQ)	Spitzer, Kroenke & Williams (1999)	An 11-item measure of symptoms of common mental health difficulties such as depression, anxiety, somatoform, alcohol, and eating problems.	✔	✔	✔	*http://bit.ly/3iT0QwB*

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Appendix B

Linking Clinical Problems, Symptoms, Treatment Options, and Resources

This table offers LIPI clinicians a variety of examples to draw from when designing a client's individualised treatment plan. A selection of presenting symptoms, suitable treatment options, and freely available online resources are detailed. This is not intended as an exhaustive list, but rather a guide to designing and implementing LIPIs. The Centre for Clinical Interventions (CCI) offer a vast number of additional clinician resources on their website, including video demonstrations (*www.cci.health.wa.gov.au/Training/Demonstration-Videos*). All sources provided in this table can be found by either clicking the hyperlink (if viewing this document electronically) or by visiting *www.cci.health.wa.gov.au/Resources/For-Clinicians*.

BEHAVIOURS			
Clinical Problem	**Symptom**	**Treatment Option**	**Online Resource(s)**
Depression	Napping while watching TV	Behavioural activation	*Weekly activity schedule* *Fun activities catalogue* *Weekly goals record* *Behavioural strategies for managing depression* *Sleep hygiene*
Generalised Anxiety	Pre-empting negative outcomes	Cognitive restructuring Psychoeducation on intolerance of uncertainty	*Unhelpful thinking styles* *Accepting uncertainty* *Postpone your worry*
Social Anxiety	Leave the event early	Behavioural experiment(s) Psychoeducation on safety behaviours	*What is social anxiety?* *Behavioural experiments* *What are safety behaviours?* *What is distress intolerance?*
Panic	Avoidance	Behavioural experiment(s) Psychoeducation on safety behaviours	*Behavioural experiments*
Sleep	Stay in bed later	Sleep hygiene	*Sleep diary* *Sleep Hygiene*
Stress	Procrastinating tasks	Psychoeducation on stress	*Coping with stress*
THOUGHTS			
Clinical Problem	**Symptom**	**Treatment Option**	**Online Resource(s)**
Depression	Rumination on negative thoughts	Cognitive Restructuring	*Unhelpful thinking styles* *Detective work and disputation* *Thought diary (ABCDE: balanced thought)*
Generalised Anxiety	"Something bad has/will happen"	Psychoeducation about worry	*Helpful thinking* *Overview of worrying*

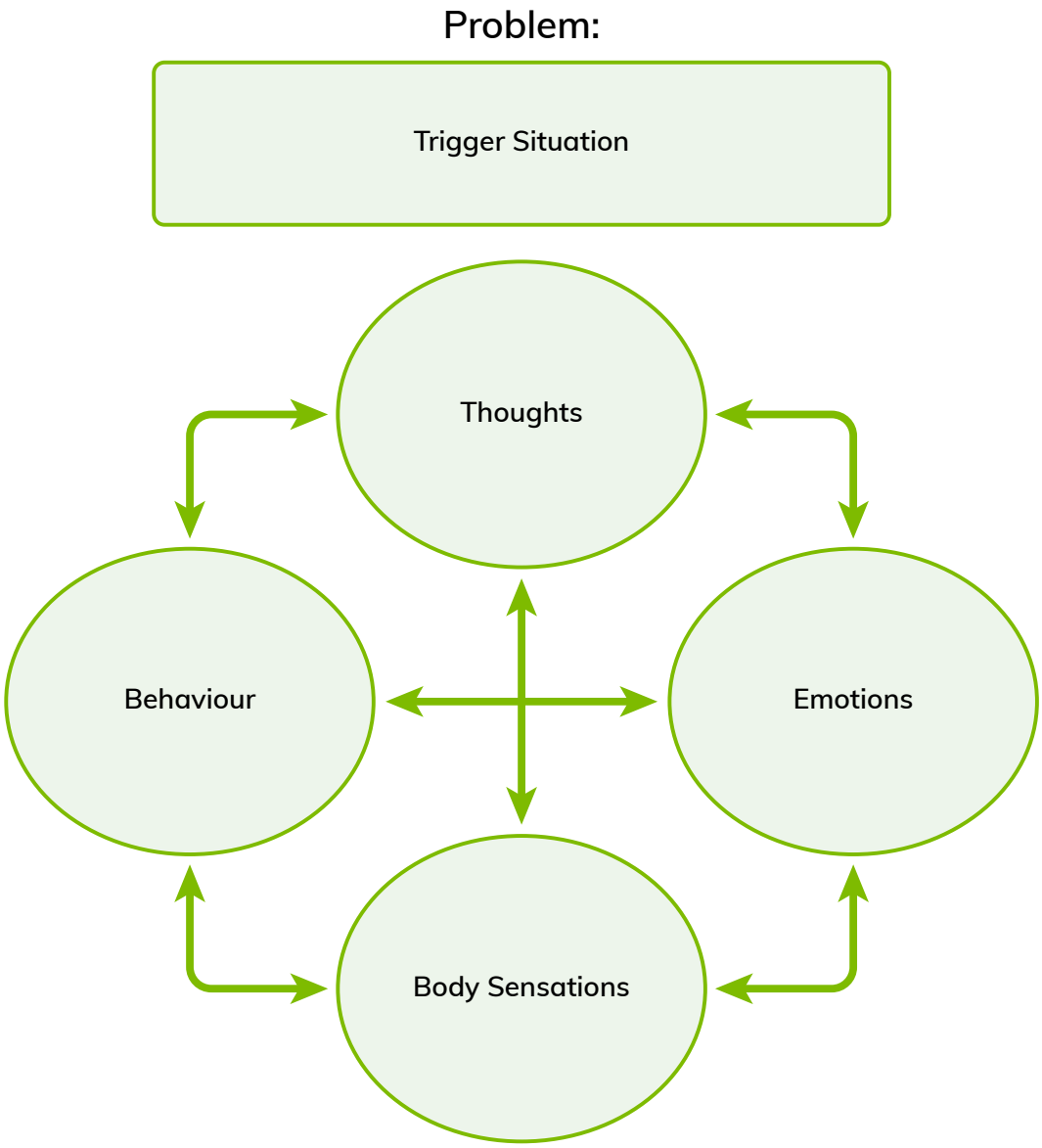
Social Anxiety	"People think I'm stupid"	Cognitive restructuring – unhelpful thinking styles, disputation	*The ABCs of thinking and feeling* *Detective work and disputation* *The thinking-feeling connection*
Panic	"I'm going to die"	Cognitive restructuring	*Thought diary (ABC)*
Sleep	"I never sleep well"	Cognitive restructuring	*Insomnia and your thinking*
Stress	"I should be doing this"	Cognitive restructuring	*"shoulding" and "musting"*
EMOTIONS			
Clinical Problem	**Symptom**	**Treatment Option**	**Online Resource(s)**
Depression	Worthlessness	Psychoeducation	*Making the connection between thoughts and feelings* *Understanding self-compassion*
Generalised Anxiety	Irritability	Relaxation	*Letting go with mindfulness*
Social Anxiety	Nervousness	Relaxation	*Progressive muscle relaxation* *Monitoring your relaxation level*
Panic	Fear	Exposure	*Situational exposure* *Situational exposure diary*
Sleep	Frustration	Relaxation	*The calming technique: breathing*
Stress	Anger	Psychoeducation	*Anger coping strategies*

BODY SENSATIONS			
Clinical Problem	**Symptom**	**Treatment Option**	**Online Resource(s)**
Depression	Low energy	Sleep hygiene	*Sleep hygiene* *Facts about sleep*
Generalised Anxiety	Tension	Relaxation training	*Progressive muscle relaxation*
Social Anxiety	Racing heart	Relaxation training	*Graded exposure: building situation stepladders* *Breathing retraining*
Panic	Difficulty breathing	Relaxation training	*Breathing retraining* *Daily record of breathing rate*
Sleep	Exhaustion	Relaxation training	*What is mindfulness?*
Stress	Feeling 'heavy' or 'weighted'	Relaxation training	*Progressive muscle relaxation*

Appendix C

Handout 2.1

Hot Cross Bun Formulation Model



Appendix D

Handout 2.2

Individual LIPI Formulation and Treatment Plan

The clinical problem(s) to be treated

1.
2.
3.

Problem statement: In client's words

Problem formulation

Use case formulation handout (Hot Cross Bun Model) to complete this section.

Thoughts

Behaviours

Body sensations

Emotions

Formulation

Identify specific treatment goals

1.
2.
3.

Identify the most appropriate LIPI modality

Consider client preference and available resources. Tick all that apply.

☐ Self-help: written

☐ Self-help: online

☐ Guided self-help: telephone

☐ Guided self-help: video-conferencing

☐ Face-to-Face individual (number of sessions ____)

☐ Face-to-face group (number of sessions ____)

☐ High intensity treatment is indicated (provide details):

Plan intervention

What resources are available within your service and what additional resources may be needed (e.g., psychoeducation materials, handouts, online resources; see Chapter 3).

List helpful resources for intervention (hard copy, online)

-
-

Based on case formulation and treatment goals, which strategies are indicated:

-
-

Treatment session plan

Provide a brief description of what each treatment session will involve:

Session 1

Session 2

Session 3

Session 4

Session 5

Outcome Monitoring

What measures will be used to monitor treatment targets?

How often will the measures be administered? (e.g., baseline and every session)

What would indicate treatment has been successful?

Referral to other services?

☐ Not currently required

☐ Required (provide details)

☐ May be required (to be determined following the LIPI)

Consider referral to higher intensity services if symptoms persist or worsen after treatment.

Appendix E

Handout 2.3

Quick Guide to LIPI Assessment

Assessing the client's problem(s)	
What	What occurs during the problem situation? What improves or worsens the problem?
Who	Whom does the problem involve? Who improves or worsens the problem?
Where	Where does the problem usually happen? Are there places it does not happen?
Why	What is the client's understanding of why the problem happens?
When	When is the problem most and least likely to happen?
Consider	
Onset	Just before the problem occurs, what is happening?
Frequency	How often is the problem happening?
Intensity	How much distress does the problem cause the client?
Duration	When the problem happens, how long does it last for?
Formulation	
Trigger/Precipitant/Antecedent	An event, situation, thought, memory, body sensation, mood, or behaviour that precedes a shift in thinking, behaviour, or mood
Consequences	Explore the consequences of the behavioural responses to the triggers. Long-term or short-term relief? If so, how long did this relief last? Were there any consequences of using safety behaviours? What impact does the behaviour have on the client's relationships? Is it possible to test whether beliefs are correct or incorrect when using this strategy?
Thoughts	A thought or an image that is unwanted, catastrophic, negative, or insulting
Feelings	Emotional, mood, and physiological state
Safety behaviour	Any behaviour that the client believes helps them to avoid a negative outcome or an uncomfortable or distressing state. May be intentional or unintentional.
Notice	
Appearance and behaviour	Such as hygiene, appearing anxious or agitated

Speech	Such as rapid, slow, or monotone
Mood	Such as sleep, appetite, interest, energy
Thought content	Such as catastrophising, expressions of worthlessness or hopelessness
Insight	Does the client think something is wrong or have an idea of how to improve it
Perceptual abnormality	Such as any odd experiences, such as hallucinations, that would require more specialised assessment
High Risk Groups	
Age	15-35 years or older than 65 years, especially among males
History	Deliberate self-harm and/or suicide attempts, particularly those by violence means such as weapons or hanging; family history of completed suicide; substance misuse; serious illness or disability; forensic / criminal involvement;
Loss	Divorce or a recent relationship loss
Cultural	Indigenous peoples
Other	Expressions of hopelessness; unemployment

This information has been taken from Hughes, Herron and Younge (2014), which is recommended for further reading on LIPIs.

Appendix F

Handout 4.1

Group LIPI Design and Session Plan

The clinical problem(s) to be treated

1.
2.
3.

Problem statement

Problem formulation

Use case formulation handout: Hot Cross Bun Model
Thoughts

Behaviours

Body sensations

Emotions

Formulation

Session details

Provide details on session length, time and day, and frequency, and total number of sessions.
Session length (e.g., 30mins, 60 mins)

Session time and day

Session frequency (e.g., weekly, fortnightly)

Number of sessions (e.g., 6 sessions, 10 sessions)

Location details

Consider where the group will be held and a room set-up that is appropriate for the group purpose.

Location of group (e.g., within the clinic, at a medical centre, town library)

Does this location have adequate:
☐ Parking

☐ Public transport

☐ Accessibility

Room set-up and required materials (e.g., whiteboard, chairs, etc)

Recruitment details

How will clients be recruited to the program? Tick all that apply.
☐ Internal client referral

☐ External client referral (e.g., GPs, other services)

☐ Promotional materials distributed to medical clinic waiting rooms etc

☐ Other (provide details)

How many participants will be recruited to the group?

Identify specific treatment goals

1.

2.

Identify the most appropriate LIPI modality

Consider client preference and available resources. Tick all that apply.

☐ Self-help: written, online

☐ Guided self-help telephone

☐ Guided self-help video-conferencing

☐ Guided self-help online

☐ Face-to-Face individual (Number of sessions____)

☐ Face-to-face group (Number of sessions ____)

☐ High intensity treatment is indicated: _____

All clients will be directed to use PORTs (if eligible) or Mindspot.org.au (if ineligible for PORTs) until the group treatment can commence.

Plan intervention

Determine what services are available within your workplace, and link to additional resources if needed (e.g., psychoeducation materials, handouts, online resources, see Chapter 3)

List helpful resources for intervention (hard copy, online)

-

Based on case formulation and treatment goals, which strategies are indicated:

-
-

Treatment session plan

Provide a brief description of what each treatment session will involve:

Session 1

Session 2

Session 3

Session 4

Session 5

Outcome monitoring

What measures will be used to monitor treatment targets?

How often will the measures be administered? (e.g., baseline and every session)

What would indicate treatment has been successful?

Referral to other services?

☐ Not currently required

☐ Required (provide details)

☐ May be required (to be determined following the LIPI)

Consider referral to higher intensity services if symptoms persist or worsen after group treatment.

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Acknowledgement

WA Primary Health Alliance acknowledges and pays respect to the Traditional Owners and Elders of this country and recognises the significant importance of their cultural heritage, values and beliefs and how these contribute to the positive health and wellbeing of the whole community.

info@wapha.org.au
1300 855 702
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ISBN 978-0-6451042-0-2

11891 jaz.com.au 0620