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Good practice guidance on the use of self-help materials within IAPT services

March 2010

“Relieving distress, transforming lives”

Foreword

This guide was produced following an Improving Access to Psychological Therapies (IAPT) Conference held at the Queens Hotel in Leeds in February 2009. The conference had been organised in response to feedback from services and those attending training courses expressing a need for expert guidance on the use of self-help materials given the wide range of different materials and media all purporting to offer helpful advice and information to people about a range of problems and disorders.

A conference was organised with expert researchers and practitioners who had experience of developing self-help materials in order to discuss whether guidance should be forthcoming and in which form it should take. Rather than endorsing particular self-help materials that are available, the conference focused on attempting to derive a set of criteria by which both practitioners and people might be able to assess the utility and effectiveness of particular materials. It was agreed that these principles might provide the basis for a 'Good Practice Guide' about how to choose and use self-help materials.

This guide has been written by the contributors to the conference (listed in Annex 1). Presentations from the conference are also available on the IAPT website (www.iapt.nhs.uk).

Professor Graham Turpin

IAPT National Advisor, Education and Training and
Self Help Good Practice Guide Practice Editor.

Acknowledgement

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I Introduction

Bibliotherapy and self-help books and leaflets have been around for as long as psychotherapy has existed. For example, *Psycho-analysis for Normal People* by Geraldine Coster was published in 1926 and as well as educating the reader about Freud, attempted to distil Freud's psychodynamic theory into a series of helpful hints and advice for non-professionals, especially parents. Self-help publications have continued to fill ever-burgeoning bookshop shelves, usually under the headings of 'Health and Well-being' or 'Self-help'.

Many charities and organisations, including the NHS, have sought to produce information booklets and leaflets. This is seen as good practice and services are generally encouraged to provide accessible information to people about their condition and its treatment (Department of Health, 2001; King's Fund, 2003). Indeed, some mental health services have pioneered the development of self-help information and developed information sheets that have been used nationally (for example, <http://www.ntw.nhs.uk/pic/leaflet.php?s=selfhelp>) and more recently NICE has provided patient information to support the publication of their clinical guidelines. (For example see: <http://guidance.nice.org.uk/CG90/PublicInfo/pdf/English> .)

Self-help materials have come to be seen both as psychological interventions in their own right or also as an adjunct to therapist-delivered care; this guide is primarily concerned with the former. Such interventions have often been referred to as 'psychoeducation' or bibliotherapy. Psychoeducation is a more general approach involving the provision of therapeutic information, which could include written materials, support and advice from professionals, and also group discussion and teaching sessions. Practitioners have also promoted bibliotherapy, defined here as the unsupported use of written materials, and at the same time quality assured or specifically endorsed those self-help books and materials considered to be effective. This type of development is often referred to as a 'book prescription scheme or service' and was pioneered some years ago by Neil Frude with the involvement of public lending libraries in the Cardiff area (<http://www.fiveareas.com/bookprescriptionschemes/>). In addition to self-help books and leaflets, a range of cassette tapes, DVDs and computer programmes (CD-ROM or web-based) are now available. There are several UK compendiums of self-help materials including a guide to the delivery of self-help CBT for services produced by Bexley Care Trust (www.mindinbexley.org.uk) and the self-help resource directory from the University of Huddersfield (www2.hud.ac.uk/hhs/mhrg/2008_self_help_directory.pdf).

So what constitutes self-help? Lucock has defined Guided Self-Help (GSH) as a structured treatment method with which the patient can help themselves with some support from another person. There is a distinction between simply providing information to people and providing guided self-help. GSH is a more structured approach which requires the recipient to work with the contents of the self-help material to overcome their problems and achieve their goals. Most current recommended self-help approaches use a cognitive, behavioural or problem-solving approach.

Although guided self-help interventions can vary a great deal, particularly in terms of number and length of sessions, we suggest the following main elements of guided self-help are:

- Engaging the person in guided self-help
- Identifying key problems and goals to work on
- Identifying appropriate self-help materials
- Supporting the person in their efforts to change
- Review progress and the need for further help
- Use of assessment and outcome measures to help assessment and review of progress

The guidance may be provided face to face or by telephone, email or websites. It is important to be flexible and innovative in the type of self-help materials and the support given. These principles are discussed further in materials produced for the Look SHARP self-help in primary care project (Lawson et al., 2009).

Various different aspects of self-help have been extensively evaluated and systematically reviewed for anxiety (Bower et al, 2001; Gellatly et al, 2007; Hirai & Clum, 2006) and depression ((Anderson et al, 2005; Gellatly et al, 2007; Gregory et al, 2004) and has been endorsed as an intervention for mild to moderate anxiety and depression by a series of NICE recommendations (NICE, 2004; NICE, 2006b; NICE, 2009a; NICE,2009b). Accordingly, it has become a major component of 'low-intensity' interventions for common mental health problems, which contribute to the Improving Access to Psychological Therapies Programme (low-intensity interventions are discussed more fully in the section below). Self-help materials along with service user or patient support groups¹ and community education have also been primary features of programmes targeting depression in Scotland and pioneered by Chris Williams and Jim White.

However, there has been debate about the effectiveness of psychoeducation or bibliotherapy and whether some forms of self-help materials are more effective than others (Richardson et al, 2008). The research evidence suggests that *guided* self-help where a practitioner is involved in supporting or coaching the person is far more effective than the provision of information alone (Gellatly et al. 2007). Nevertheless, bibliotherapy

1 How we refer to people using IAPT services is a difficult and contentious issue. Unlike people with enduring mental health problems who may construe themselves as service users or survivors, many people being treated in IAPT services having been referred by their GP will either consider themselves as patients or people. Many therapists will regard them as clients. Hence, there is no universally agreed term. We have used the terms either "people" or "patients" in this guide to be consistent with other IAPT teaching materials that have been made available for PWP.

and internet delivered CBT for social anxiety has been shown to be effective without direct therapist contact (Furmack, et al., 2009). So it would appear that how self-help is provided may determine its efficacy. Moreover, it is likely that for some disorders such as PTSD, self-help or psychoeducational approaches may be ineffective (Scholes et al, 2007) or even potentially harmful (Wessely et al, 2008).

It should also be remembered that there may be individual differences in cognitive style or personality as to whether people want to be informed about their problems and how they might cope better. Within physical health care there is an extensive literature about individual differences in coping with invasive medical procedures (Ludwick-Rosenthal & Neufeld,1988). Recently, an analogue study of self-help in undergraduate students suggested that exposure to self-help materials for students with a tendency to ruminate could actually lead to negative consequences for their mood and wellbeing (Haeffel, 2010). Whether this generalises to more clinical settings has yet to be studied.

Within the context of developing IAPT services, it would seem superficially that the use of self-help materials by both services and education providers should not be a demanding task given the choice of the myriad of such materials that are now commercially available.² However, choice is the essence of the problem and many IAPT services have reported not knowing which materials are effective and should be employed within their local services. As discussed in the Foreword, this was the impetus for organising a conference on self-help and IAPT and also for developing this guide.

The following chapters discuss a range of issues surrounding the effective deployment of self-help strategies and materials. They have been written collectively by the original contributors to the conference, as listed in Annex I.

2 This guide has deliberately avoided endorsing or recommending any particular self-help products. However, it is hoped that after reading this guide a professional will be sufficiently knowledgeable to employ the principles identified herein to evaluate the utility of those particular products referenced within the text. We would suggest that such choices are made in discussion with individual patients. Indeed, we plan to provide a simplified and shortened digest based on this guide for both people using and providing services. It should also be read in conjunction with the other IAPT instructional manuals for students, lecturers and supervisors.

II What are low-intensity psychological interventions?

Low-intensity psychological interventions are multi-dimensional, encompassing different elements of content, duration and delivery. A low-intensity intervention, such as self-help, may use simple or 'single strand' approaches that are less complex to undertake than formal psychotherapy; contact with people is generally briefer than in other forms of therapy and can be delivered by paraprofessionals or peer supporters using non-traditional methods such as the telephone or the internet.

Low-intensity psychological interventions do not exist as a separate entity, remote from other mental health services. Rather, they are embedded in systems of treatment delivery, which ensures that people receive the intervention that is most appropriate for their needs. The principal system is stepped care, although other ways of organising low-intensity treatment, such as 'collaborative care', do exist.

The provision of low-intensity psychological interventions gives people choice and flexibility. Such interventions are designed to increase access to evidence-based psychological treatments on the understanding that many people will derive benefit without recourse to a more intensive psychological therapy programme.

Low-intensity psychological interventions are delivered on the explicit premise that people are the best managers of their own mental health. Workers who deliver these treatments support people in using evidence-based information to regain their self-management abilities, where these have been adversely affected by mental distress. The intervention involves giving information to people about their mental health problems and ways to overcome them. It also involves helping people through a supportive therapeutic alliance to make the best use of both this information and their own strengths.

Psychological well-being practitioners

Low-intensity workers have been referred to by a number of job names including coach, case manager, graduate worker and self-help support worker. The preferred job title used by IAPT is the psychological well-being practitioner (PWP). Psychological well-being practitioners, as well as offering guided self-help, may also spend time organising additional support from external agencies and liaising between these agencies and the person (i.e. 'sign posting'). This may also involve promoting good community engagement, especially for people who may be difficult to engage. PWPs may also be involved in working with GPs and other staff to help primary care deliver the best service. This 'case management' can require considerable liaison skills.

PWPs also support people who wish to take medication, such as antidepressants, for their emotional problems. This involves supporting people to make a fully informed decision and, having done so, to ensure that they know how to take their medication in such a way that maximises its effects. PWPs are also able to educate people about unwanted effects and their likely course and duration, bearing in mind that at all times the prescriber, usually a GP, retains full responsibility for the medical management of the person's care.

Careful supervision is required in order to monitor the progress of all people included within the PWP's caseload. This is an essential component of the low-intensity clinical method (see later) and is done through collecting routine outcome measures at each clinical contact and using these measures as feedback during treatment and as part of clinical supervision. Such monitoring allows decisions to be taken about 'stepping up' to more intensive interventions, if a person is not making the expected progress or is deteriorating. This self-correcting mechanism is essential to effective self-help.

Although supervision has many functions, low-intensity work requires a particular form of supervision called 'clinical case management' supervision. Clinical case management supervision is patient-centred and should incorporate the review of individual clinical outcomes and focus on helping workers manage their whole caseload by discussing individual cases at pre-determined intervals. (See the IAPT Good Practice Guide on Supervision: <http://www.iapt.nhs.uk/2008/12/17/iapt-supervision-guidance>; A specific manual for PWP supervisors is due to be published through IAPT in spring 2010).

The content of low-intensity treatments

At the time of writing, the only substantial evidence for self-help based low-intensity interventions is for those informed by cognitive-behavioural principles. Non-CBT based low-intensity treatments have either been shown to be ineffective or as yet have no evidence base. Accordingly, low-intensity CBT interventions focus on the use of CBT self-help materials and techniques, which emphasize the interaction between physical, behavioural and cognitive symptoms, and the value of between-session homework.

Single strand interventions include those that address the physical or autonomic aspects of a person's difficulties, such as approaches to improve sleep, diet or mood. Behavioural interventions include behavioural activation for depression, graded exposure for phobic anxiety and exercise for depression. Cognitive techniques include some of the simpler cognitive restructuring methods to identify and redress negative automatic thoughts and thinking errors. Other interventions include problem solving techniques. The content of effective self-help materials should, therefore, explicitly refer to these principles and include exercises that help people overcome the cognitive-behavioural factors maintaining their difficulties. In low-intensity working, the self-help materials are the focus of treatment, rather than an adjunct

The duration of low-intensity treatments

Compared with traditional psychological therapies, low-intensity treatments are typically limited in terms of the amount of time the practitioner is in contact with a person. This can be because people are seen for a shorter amount of time in each contact (ie typically less than the traditional one hour session) or for fewer sessions overall. If treatment is being delivered via the telephone or email or by using computerised CBT (see below) this too will also reduce the amount of contact time.

There is no arbitrary 'session limit' to low-intensity CBT. Evidence from the IAPT demonstration site in Doncaster showed that the mean number of sessions was around five per person, but some people had considerably fewer sessions and others many

more. Low-intensity treatment should be continued until there is no reason to do so, either because the person has benefited as much as can be expected. Where people have shown no signs of likely benefit from low-intensity treatment, PWPs should consider within supervision offering to 'step them up' to a high-intensity treatment.

The delivery of low-intensity treatments

PWPs delivering low-intensity treatments carry out their work using a variety of flexible and accessible formats. Although face-to-face working is part of this, the use of the telephone, email, groups and computerised CBT all improve access and choice. Many people are unable to access scheduled face to face appointments and there is evidence of delivering therapy remotely by the use of the internet or telephone (Bee et al, 2008; Car & Sheikh, 2003)

Low-intensity interventions are also designed so that people without formal healthcare professional or CBT therapist qualifications can deliver treatment. Nonetheless, specific training in the low-intensity method is known to predict better outcomes (Bower et al, 2006). PWPs are specifically trained to deliver low-intensity interventions through the IAPT national curriculum and as such are well trained and highly qualified for the role. It is also known that practitioners who are trained in how to introduce and support self-help feel more confident and are more positive about self-help than others who have not been trained (Keeley et al, 2002).

Supporting low-intensity treatments and PWPs

The content of low-intensity treatment can be seen as the 'specific factors' in a psychological treatment programme. PWPs also have to develop considerable expertise in the 'common factors' associated with effective psychological interventions. These include strategies to establish, develop and maintain the therapeutic alliance, such as warmth, empathy, listening skills, reflection, summarising, questioning skills and the ability to problem solve collaboratively any difficulties in the person's treatment plan or the relationship between the PWP and the person. See Part III for further discussion of specific and common factors.

Supervision, particularly clinical case management supervision, supports PWPs' decision making and treatment delivery. It should be conducted weekly and include a review of case load numbers and a discussion of the following: all new people; those that have high clinical measures scores; all people who reach various stages in treatment (4, 8 and 12 weeks); those whom the PWP feels are ready for discharge; those who are causing the PWP difficulty through issues of potential risk or other factors; and those who have not attended appointments or with whom the PWP has lost contact. Notification of these people during supervision sessions is best achieved through automated IT-based patient management programmes so that supervisors and PWPs can have access to the same algorithm-defined lists, which are generated weekly. PWPs also need to be given supervision and support to develop and maintain their clinical skills; such skills development could be provided through more traditional individual or group clinical supervision sessions.

Further support to PWP working is provided by the stepped care system. Low-intensity interventions are best delivered in a workplace that comprises qualified low-intensity workers, low-intensity trainees, qualified high-intensity workers and high-intensity trainees. Stepping up people from low- to high-intensity is likely to be far more seamless if teams of low- and high-intensity workers operate from the same base in the same service. Such environments reduce the need for cross-service referral systems or multiple assessments and allow team discussions and supervision to occur more readily.

In summary, low-intensity treatments are designed to be easily accessible, well utilised and acceptable to people. Compared to more formal psychotherapies, they take less time, are less intensive and can be delivered and supported by paraprofessional workers, albeit trained to a high level of specific competence in their delivery. Low-intensity interventions must be embedded in systems of support including high-quality therapeutic alliances, flexible delivery systems, clinical case management supervision and integrated stepped care systems.

III How to choose effective self-help materials

In the first part of this 'Good Practice Guide' we looked at the growing evidence base surrounding the use of CBT-based self-help for the treatment of common mental health problems. However there are limits to this evidence base, and further research is required looking at the efficacy of self help both across the range of disorders and also the manner in which it might be delivered (i.e. guided vs unsupported, written vs internet etc). Consideration needs to be given to situations, therefore, when the evidence base does not exist, where self-help has not been convincingly demonstrated as effective or when it may even do harm.

It also follows, therefore, that not all self-help materials may be effective and that different materials might be more or less suitable for individual patients. Within Part III, we deal, therefore, with the fundamental task facing PWPs and other therapists as to how they choose and select individual self-help books for particular patients. There are four sections. The first section challenges the notion of universal endorsement and that self-help will always be benign, and examines the potential for self-help books to cause harm. It is argued that there is an important need for more discriminating and evidence-informed prescribing. In some circumstances, the practitioner has to decide that self-help may not be warranted at all. The second section sets out the key components or factors that contribute to the effectiveness of self-help materials. The third section provides specific advice for PWPs to help them make choices between the myriad of titles available and to approach such selections in a systematic fashion. Finally, important factors regarding the content and presentation of self-help materials are discussed by a user perspective based upon a patient survey of self-help materials.

Addressing the potential for CBT self-help to do harm

The call to establish an evidence base before recommending self-help materials is not new. In 1978 the American Psychological Association (APA) established a self-help task force to address potential dangers of self-help (Rosen, 1976). These dangers were largely based on clinicians recommending self-help materials that had undergone very little, or often no, scientific testing. Rosen and the APA Task Force initially proposed that self-help books should undergo the same rigorous randomised controlled trials as other interventions. However, because of excessive costs and time in undertaking such trials for each title, a compromise position was later proposed. This suggested that all self-help books without a specific evidence base should include declarations that although not tested, they were based on treatment interventions that are accepted within clinical settings and furthermore should advise seeking professional help if the book is not successful. These recommendations, however, never came to fruition.

Nevertheless, there does now exist an accumulation of research into the effectiveness of guided CBT self-help across a variety of common mental health problems such as depression (Anderson et al, 2005; Gellatly et al, 2007; Gregory et al, 2004); anxiety and depression (Bower et al, 2001; Den Boer et al, 2004); anxiety (Cuijpers & Schuurmans, 2007); bulimia nervosa and binge eating disorder (Perkins et al, 2006); insomnia (Van

Straten & Cuijpers, 2009); mild alcohol misuse (Mains & Scogin, 2003); and panic disorder (Hirai & Clum, 2006).

Demonstrated effectiveness, however, does not necessarily translate into availability and use. Many books that have been subjected to scientific testing using Randomised Control Trials (RCTs), for conditions such as depression (e.g. Floyd et al, 2004; Jamison & Scogin, 1995) or panic (e.g. Febraro et al, 1999; Febraro, 2005; Gould & Clum, 1995; Hecker et al, 1996) are difficult to come by especially within the UK. Well researched books such as 'Coping with Panic' (Clum, 1990), 'Managing Anxiety and Depression' (Holdsworth & Paxton, 1999) and 'What Should I Do? A Handy Guide to Managing Depression and Anxiety' (Kennedy & Lovell, 2005) are often difficult to source.

In recent years a move to using a professional consensus approach when recommending self-help books has been adopted, as evident in Books on Prescription Schemes (BoP) (Frude, 2004; Farrand, 2005) and in guides to self-help resources. Norcross and colleagues, for example, developed the *Authoritative Guide to Self-Help Resources in Mental Health* (2000) collating recommendations for self-help books from over 2,500 members of the APA. However, there are several reasons why professional opinion is not appropriate to inform the selection of self-help books (Richardson et al, 2008). As with recommendations from the general public, the actual popularity of any self-help title seems to influence whether a book is recommended. However a book's popularity has more to do with the profile of the author or the publicity budgets of the publisher than a reflection of the evidence base of the book. Furthermore, personal recommendations are only as good as the extent to which the professional has actually fully read and assessed the recommended title. In addition, books that have been well evaluated and are easily available, may not necessarily feature in BoP schemes. Examples are titles such as 'Stop Obsessing!' (Foa & Wilson, 2001), 'Shyness and Social Anxiety Workbook' (Antony & Swinson, 2000) and 'Mastery of Your Anxiety and Panic' (Barlow & Craske, 1989), which do not necessarily feature prominently. This raises the nature of the criteria that professional consensus panels adopt in order to recommend titles and whether there are based upon the strength of the underlining evidence base?

The limitations highlighted above have led to a re-examination of the top 50 self-help books in the USA, not all of which are based on CBT (Redding et al, 2008). This review was based upon characteristics of self-help books previously reported to correspond to effectiveness (Glasgow & Rosen, 1978; Pardeck, 1993; Rosen 1981, 1987). Redding et al (2008) reported concern with 18% of the books considered to potentially provide iatrogenic advice. For example they cite how one CBT self-help title proposes extensive use of distraction techniques that could possibly worsen symptoms (Hannan & Tolin, 2005). It is essential, therefore, that self-help titles do not propose interventions unless adequate research points to their effectiveness (Redding et al, 2008). Furthermore they also highlight the example of another title that provides the following advice about exposure therapy: 'If your anxiety feels like it's starting to get unmanageable (above 5 on the anxiety scale) then you should temporarily retreat from the situation' (Bourne,

2001, p. 143). This may contradict the advice that a PWP may give, which would be to encourage the patient to stay in the situation until their anxiety reduced by half. Before using any specific book, the PWP should carefully read the book for themselves and therefore ensure that any advice given within is consistent with advice that they themselves would provide.

In summary, the belief that 'self-administered treatment is at least benign' (Floyd et al, 2004, pp. 115) is, at the very least, controversial. Greater consideration is required by all mental health practitioners before they recommend a specific CBT self-help book to patients.

Self-help materials: specific factors, common factors and personal experience Our understanding of "self-help" materials is becoming increasingly more sophisticated and has extended beyond just the mere provision of written information. In their review of self-help books, Richardson and colleagues (2008) suggest that a second generation of self-help books should be specifically designed to '*pay attention not only to their core evidence base but also to their ease of use – including their readability, their structure and their approach to engage readers*' (p. 551).

In addition there are three factors that are essential for an effective self-help guide. These are:

Specific factors: CBT has developed technical and specific 'empirically grounded' evidence-based therapeutic procedures that 'work'. Indeed, it would seem that non-CBT based self-help books do not work (Gellatly et al, 2007). However, less than a quarter of the most easily accessed and popular 150 self-help books for depression are CBT based (Richardson et al, 2008). There are many self-help books, some on BoP lists, which do not include evidence-based procedures or, worse, give advice which might be positively harmful even in apparently evidenced-based books detailing CBT procedures (Redding et al, 2008). Choosing the 'right' book requires PWPs to engage in careful study and familiarisation to check that the advice is CBT-based and true to the principles therein. Specific CBT advice will relate directly to the disorder but common aspects of CBT such as the general cognitive emotional model, monitoring and self-assessment, and action orientated tasks and homework are likely to be common CBT specific factors.

Common factors: CBT therapists have long recognised the importance of the therapeutic alliance. For example:

"...the importance of the relationship between patient and therapist [is] the single factor which seems most relevant to the outcome of behaviour therapy." (Meyer & Gelder, 1963, p26)

"You will get further with a patient with a good therapeutic relationship and a lousy technique, than you will with good techniques and a lousy relationship" (Meyer. quoted in Bruch and Bond, 1998, p141).

Recent work (Richardson and Richards, 2006) has questioned whether self-help books themselves can recreate some of these 'common factors' or whether these are the exclusive preserve of the human interaction between a person and a health worker. A detailed study (Richardson et al, 2010) of three of the most popular books with a range

of low, medium and high reading ages demonstrated that these books use more basic common factors such as empathy, warmth and genuineness rather than other sophisticated common factors such as flexibility and responsiveness, both strategies to improve 'stickability' in therapy. Common factors that are used to establish a therapeutic relationship with the reader are more prevalent in self-help books than those factors used to develop and maintain that relationship. In other words, it is easy to pick up self-help books for the first time, easier still to put them down and most difficult of all to pick them up again.

Personal narratives: Narratives are used by people to describe their emotional distress--when people describe their experiences they often use metaphors to convey a sense of struggle with their difficulties. People report positively on books that include narratives that echo their own experience (MacDonald et al, 2007). While stories of recovery are important in books (for example, Lovell & Richards, 2008), so are stories of struggle. Stories should give people hope but should not be so unrealistically positive that they appear false.

Specific factors, common factors and personal narratives should be evenly balanced in any self-help book used by PWP. Self-help materials, and the guidance that supports them, should use similar language and metaphors to those voiced by people to enhance communication and to maximise the resources people already bring with them. People might be self-therapists, but both books and workers must endeavor to redress prior beliefs about passivity and develop a working alliance with people that focuses on the self as the agent of change.

Readability, cultural appropriateness and accessibility. Studies of the large number of self-help books available (Martinez et al, 2008; Richardson et al, 2008) have shown that many have a complex structure and are written at above average literacy levels, and less than a quarter of them are CBT-based. Assessing and matching the readability of the materials to the literacy level of either the individual or the community is an important consideration in implementing any self-help intervention. Similarly, matching the language and cultural/ethnic representation of materials to local communities, together with adaptations for sensory (i.e. visual and hearing impairments) are also essential. In London, many IAPT self-help materials have been translated into languages frequently spoken in the community (<http://www.workingforwellness.org.uk/resources/translated-materials/>). Nevertheless, translation may not mean that the materials are culturally appropriate (Watts & Robjant, 2008). Moreover, services and PWP practitioners may first need to engage with communities and community leaders to understand their particular needs and how to access and engage the community (Jamieson & White, 2008) For example, in Newham although the diversity of languages spoken within the community was a major barrier, the relatively high level of illiteracy within people's own language was even more problematic (Ben Wright, pers comm.. February 2010). Hence translating leaflets was not an effective strategy but recording self-help materials onto audio devices such as audio cassettes, CD Roms and MP3 players in a range of languages provided a much more accessible route than translation alone.

In summary, PWPs should choose wisely when selecting self-help books and consider the following questions:

- Are they technically accurate?
- Do they engage with people?
- Do they develop and maintain that engagement?
- Do they use the language of common factors to do so?
- Do they use personal metaphors for emotional distress?
- Do they use narratives to connect readers to real life experiences?
- Do they help the person make connections between what they are reading and their own life
- Do they provide a structure that encourages trying out what is learned and helping the person to review the outcomes?
- Are they readable and culturally/disability?

Given the fact that books will always struggle to fully replicate the more sophisticated common therapeutic techniques necessary to develop and maintain therapeutic relationships, these techniques need to be used specifically by PWP's themselves as part of the supportive relationship in guided self-help. The best way to do this is through the therapeutic relationship. Indeed, Khan and colleagues (2007) found that the development of an effective therapeutic alliance determines whether people subsequently use self-help. This goes a long way to help us understand why guided self-help is effective while non-guided work has a much more doubtful evidence base.

There is clear evidence in both anxiety and depression that self-help materials alone are clinically ineffective (Gellatly et al, 2007; Hirai & Clum, 2006). The addition of guidance renders self-help effective, however, guidance alone will also be insufficient if the self-help book chosen is poorly written, contains inaccurate information or, worse, suggests harmful or non-evidence based procedures.

The selection and use of self-help materials that are readable, engaging, factually accurate and reach out to people through believable narratives is a skilled activity requiring the right materials to be available at the right time with the right amount of guidance. Practitioners need to be supported to develop the skills to discriminate between materials and use them, appropriately guided by four principles:

- To be informed by the evidence base
- To provide a meaningful rationale for self-help materials
- To provide the appropriate amount of support
- To be supported within a system that conducts regular audit of materials.

It is important to bear in mind, however, that the effectiveness of the intervention will often depend on the skill of the practitioner in identifying the right materials for individual people, and unless a systematic approach is taken, any benefits are likely to be serendipitous and may not be long lasting. Moreover even the best book will probably fail to work without the use of skilled support from a PWP. Central to this support is helping people move from a position of therapeutic passivity to one of active engagement with their own recovery.

What should trainees look out for when choosing self-help materials, in practice?

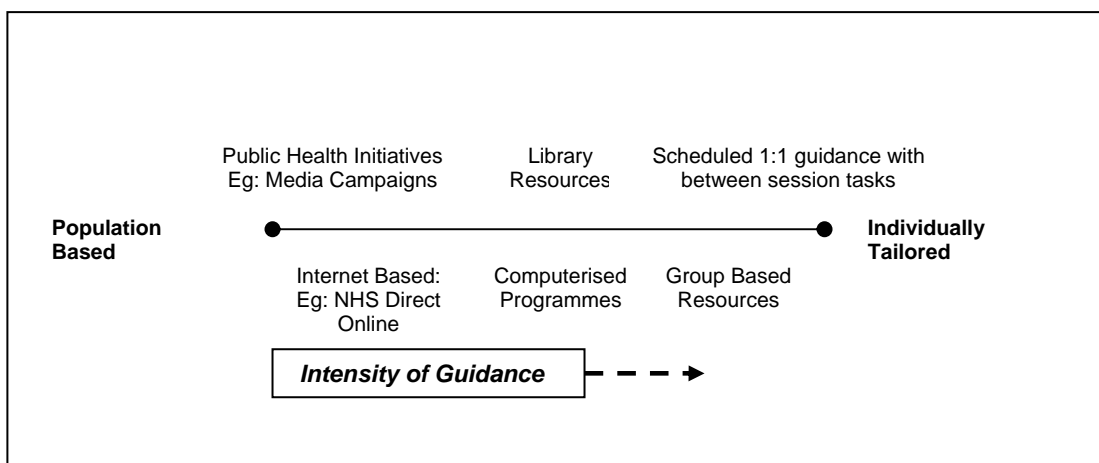
Trainee PWP's will often ask trainers about the best resources to use, and while a prescriptive approach can be helpful in the short term to get work started quickly, in the longer term the trainee should be encouraged to develop their own core skills in order to work effectively within a facilitated self-help model. These are based on a Quality Framework that has been developed at the University of Manchester (see Annex II) and are based on the following principles:

- developing an enquiring approach based on knowledge of the underpinning principles on which the materials are based
- the ability to critically reflect upon the quality of the material
- the skill to adapt the use of the materials as appropriate to meet individual need.
- the ability to effectively introduce and support the materials with the patient

Within this context PWP's need to develop and maintain the skills to become active critical appraisers of self-help resources - knowing what to look for and how to use them to best effect. They also need to be aware that the clinician's view of what is best has to be combined with the person's own views of what is helpful and appropriate if the aim is to work with them in partnership towards recovery.

In order to understand the range of self-help materials and how they can be appropriately used as part of facilitated self-help it can be helpful to visualise that they exist on a continuum defined by the degree of guidance and support that the person will need in order to use them. Figure 1 shows the range of materials that exist, with those that require minimum intensity support at one end of the continuum and those that need individualised guidance at the other.

Figure 1: The intensity of guidance dimension for self-help



The practitioner who uses self-help resources selected from any point on the continuum should have in mind three guiding principles:

- To communicate a normalising recovery-focused message
- To help recipients understand their difficulties in a timely and understandable way
- To facilitate knowledge and acquisition of evidence-based interventions to enhance self-efficacy and promote self-management.

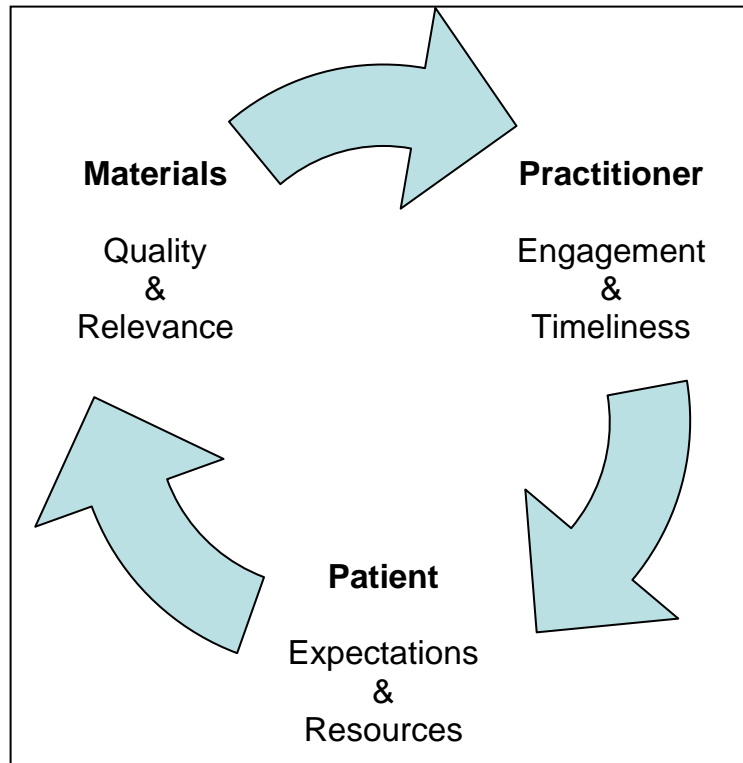
A number of recent studies have attempted to examine the moderating factors that enhance the use of self-help materials. As mentioned above, Gellatly and colleagues (2007) found that self-help interventions based on cognitive behavioural principles worked best, and were most effective when used with people who had existing problems rather than as a preventative intervention. They also found that the addition of a 'guided' component improved outcomes, but exactly how 'guided' is defined - including how much and how often - is less clear. A recent set of studies, however, examining internet CBT and bibliotherapy, together with online discussion groups, did demonstrate significant effects for bibliotherapy alone in the case of social anxiety (Furmark et al., 2009).

What is clear, however, is that initial engagement with the resource material is crucial. Khan and colleagues (2007) found that engagement needed to be based on a rationale that is clearly linked with the individual's own understanding of their problems. In support of this McDonald and colleagues (2009) highlighted that the practitioner needs to be able to provide a plausible explanation for guided self-help materials, which seeks to address the expectations of the person and locates this particular way of working within a recovery model of care. Similarly Protheroe and colleagues (2008) found engagement to be crucial when encouraging individuals to use self-management for a number of chronic conditions, including depression. They identify five key elements that influence the success of engagement:

- the person's prior knowledge about their condition
- the person's prior knowledge and understanding of self-management
- the person's ability and opportunity to apply self-management principles
- congruence of self-management with the practitioner's role
- the timeliness of the intervention.

These studies highlight that promoting self-management is a skilled activity that requires aspects of the practitioner, the person and the materials to combine to best effect (see below).

Figure 2: Factors influencing implementation of self-help



To consider the role of self-help materials in delivering low-intensity interventions we need to understand the nature of help seeking and how it interacts with low-intensity working, particularly self-help. In an influential article in the *British Medical Journal*, Rogers and colleagues (1999) outlined an important model of help seeking. They described how when people experience emotional problems they often lack two things: the *information* to help them understand and address these problems and *support* while they do this.

This combination of information and support is central to effective delivery of low-intensity CBT self-help. CBT is an active approach to recovery and requires people to undertake therapeutic exercises. Information on why this approach is likely to work (the rationale), the specific techniques themselves, recording sheets and diaries are required, *together with* interpersonal support necessary for people to put their exercises into action.

Rogers has continued her work by investigating people's experiences of self-help. This latter work (Khan et al, 2007) has considerable implications for PWPs delivering guided self-help. Khan et al (2007) reviewed nine studies that asked about people's experiences of accessing and using self-help. These studies showed that when people

seek help they feel shame and are stigmatised by having to admit they have failed to cope. They believe that getting treatment means further loss of control. They have a focus on being unable to cope, rather than their 'symptoms' and prioritise regaining everyday functioning and social roles in their recovery. Many people believe that medication can be important for *feeling* better but that *being* better is a state of improved emotional well-being in the absence of medication.

This review also showed that people's understanding of self-help interventions depended on prior experience and an awareness of the concept of self as the mechanism of change. Such awareness takes time to develop, and is difficult in the context of some of the symptoms of depression, such as low self-esteem and poor motivation. Furthermore, when people describe their views of what treatment 'is', professional actions are ascribed greater authority and power than people in bringing about therapeutic change. People often view their role as being in receipt of treatment rather than initiating therapy. Professionals have 'esoteric' knowledge and are charged with ministering to people.

These findings challenge the self-help model. If people enter treatment believing that PWP's have the knowledge and power to 'cure' them and that accepting 'treatment' means ceding control to the 'professional' PWP, they are likely to find the emphasis on self-help frustrating and at odds with their expectations. Sensitively introducing self-help materials and managing people's expectations so that they become partners in care requires tact and diplomacy. Crucially, it also requires PWP's to choose the 'right materials'. The importance of empowerment and its nurturance within self-help has been identified as a major theme by research undertaken by Lucock and colleagues (2007).

What do people with common mental health problems find helpful?

People with lived experience of common mental health problems will often search for self-help information independently before accessing help and support via their GP or an organisation. As we have seen, their perspective is very important – if the person does not engage with the material then they are unlikely to derive any benefit from it. Researchers often ask for the opinions of those who have anxiety and depression so that they are able to adapt their materials to suit their needs.

Anxiety UK is a mental health charity specialising in the dissemination of information about anxiety and related disorders in order to promote self-help. In order to explore opinions about self-help materials in preparation for last year's conference in Leeds, 20 members volunteered to complete questionnaires, with five having in-depth follow up (see Figure 3). All participants had personal experience of common mental health problems, and had used some form of self-help material in their recovery process. A summary of the survey found:

- Many people seek out self-help guides to use without the aid of a practitioner.
- Issues centre around the language used (too technical) and style of the resource (impersonal), along with difficulties around motivation to complete materials without support.
- Accessibility – self-help is often a 'first port of call' before accessing more structured support.
- Guides that seemed 'impersonal or irrelevant' in terms of their material were viewed less positively, which is an issue faced by self-help materials generally
- Many people found a structured approach helpful – breaking down materials into 'bite sized chunks' made them easier to complete.
- Good goal setting and the identification of individual issues were reported as very important in helping people understand their problem.
- Case studies were seen as an important way of helping the reader relate to the material.
- Having worksheets that could be printed out or photocopied was beneficial.

There is much overlap with many of the common factors identified in the earlier section of this guide.

Figure 3: Subjective experiences of Anxiety UK members using self-help material

'It gave a step by step guide for analyzing your problem and techniques'

'Helped me feel more normal – lots of other people had the same issues'

'I found the worksheets helpful although I did not get motivated to work systematically through it'

'I found the language a bit impersonal at times, and case studies were not relevant to my particular problem'

'It helped me to identify specific issues which were causing me distress/ anxiety and identify the steps to address these'

'Some support from another person may have helped – felt I would have done with someone helping me to take a more measured approach'

There have been several other attempts to research the patients' perspectives of self-help strategies. Lucock et al (2007) report on a consultation event with users of local mental health services. Five key themes emerged from the users' perspectives about helpful self-help strategies they use to manage their lives: the importance of structuring and managing the day, empowerment, engaging others to help yourself, physical health and wellbeing, and spirituality. Mansell (2007) also conducted a small study on individual perspectives of self-help guides, and identified a range of positive and negative points, which are outlined below.

Figure 4: Helpful and unhelpful content (Mansell, 2007)

Positive points	Negative points
<ul style="list-style-type: none"> • Easy to read • Understanding and compassionate • Encouraging and optimistic • Up-to-date information and style • Explains why avoidance makes things worse • Section on assertiveness • Realistic • 'Helps me understand myself' • Author identifies with reader as normal human being • Can easily 'dip in' • Includes vignettes on anxiety 	<ul style="list-style-type: none"> • Patronising, impersonal or distant • Only applied to a small range of anxieties • Goals for the reader are not relevant • Too basic • Too 'spiritual' • Too much irrelevant information • Need to be on the road to recovery to find it helpful • Dwells on the symptoms so much I imagine I have them • Unconvincing case examples

Key points for practitioners from a patient's or person using self-help are:

- It is important to remember personal choice when providing guided self-help, and to socialise your patient to the self-help material you are using.
- Support is important and many of the individuals surveyed said they would have preferred to have some support and someone from whom they could obtain feedback about their progress.
- Practitioners should know the materials well before they ask people to use them.

Promoting self-management and appraising resources

Finally, it is not sufficient to just choose the most appropriate self-help material for an individual but as discussed elsewhere in this guide, it is essential that patients are motivated to take responsibility for their own self-management and recovery. Some of the steps that promote such an approach are outlined below:

- Be able to provide a recovery-focused rationale based on sound knowledge of the person and their expectations of what will help them.
- Promote the person as the agent of change with appropriate practitioner support practitioner.
- Take into account the effects of symptoms (for example, poor concentration and impaired decision making) on the person's ability.
- Implement a system that monitors the process of the individual using self-help resources and reviews outcomes.

Finally we have summarised our approach developed over a number years teaching graduate mental health workers and PWP's at the University of Manchester to choose and use self-help materials in our Quality Standards Framework. This can be used as a basis for teaching and classroom exercises for trainees to explore these issues further and can be found in Annex II at the end of this guide.

IV Good practice in how self-help is delivered

We have described what constitutes guided self-help and how it contributes to the delivery of low-intensity interventions within IAPT services. In this section we focus on the context in which self-help interventions are delivered. It extends the discussion on common factors within Chapter III to specifically include strategies that PWP's can adopt in order to motivate patients to plan and benefit from the use of self-help materials. It also looks at different media that can be used for exchanging self-help information ranging from books and leaflets, through to web-based approaches. In particular, the use of the telephone as a primary and efficient means for PWP's to provide support and guidance around low intensity interventions is covered. Low intensity interventions and contacts with patients are often based on short and sometimes frequent interactions (e.g. 15 minutes) between the PWP and the patient. Such brief interventions are ideally suited to telephone contacts and indeed would be impracticable if reliant always on face-to-face contacts and travelling to and from the clinic or base..

Using different media and modes to deliver CBT self-help

We often think of CBT as being about delivering a psychological therapy. However, another way of considering CBT is to think of it as teaching and learning. From this perspective, the practitioner takes on the role of mentor, supporter, coach or teacher. Their role is to work with people ('students') to help them learn key information. That information can be provided face-to-face in longer sessions (high-intensity) or shorter sessions (low-intensity) supplemented by self-help resources (teaching materials) that aim to deliver key parts of therapy. The choice between these two kinds of interventions will be influenced by a number of factors including the nature, severity and chronicity of the person's problem, experience of previous treatment, risk and personal preference.

Because people with problems such as low mood and anxiety may have difficulties concentrating, have little motivation for embarking on and completing tasks, and feel tired most of the time, structured support (see below) is crucial in helping encourage people to use CBT self-help materials and get the most out of them. In order to engage the person fully in the intervention, the level and nature of support should be based on the initial assessment. Supportive monitoring should be employed to enable the person to use the self-help materials and remain motivated; this may include instilling hope, active encouragement and goal-setting. The person's progress should be regularly monitored to allow problem-focused solutions to be used. Telephone support can be just as effective as face-to-face contact, and is often acceptable to the person (see below).

Ultimately, the key is to combine the common factors of support with a specific support structure. This support structure assumes it is challenging for people to make changes and that most people find it difficult to put self-help approaches into practice without a clear plan. This structure, coupled with an individualised and specific 'Putting into Practice Plan', provides an outline to help change occur.

What does structured support look like? An illustrative example is the use of a simple and short aide memoir that can help structure the introduction and review of self-help for

people, and forms the basis of a 'Plan – Do – Review' support structure. The following are 15 specific suggestions that are taught in the Glasgow services when introducing the use of CBT self-help.

'15 Things that Make the Books and Web Resources Work Better (Williams, 2008)

1. Set aside a time and place to work on your project every day.
2. Don't drink alcohol or nibble while working on your plan. Tea, coffee or juice are OK though.
3. Get energised before sitting down to work. Anything that uses your muscles for a couple of minutes is OK.
4. Go through it over and over till you know it by heart. Write notes and comments. Think about what it's saying.
5. Make a plan and write it down, step by step. Be sure to make them small, simple steps that you will be able to do.
6. Think about eating an elephant. You can do it if you take lots of little mouthfuls.
7. You WILL get stuck from time to time, so work out what to do about it in advance.
8. Your plan is like a new year resolution so don't let it fade away. Check your progress every week.
9. Get a lot of help. The more people know about your plan, the more help you'll get and the more likely you are to succeed.
10. Write yourself a letter from 10 years in the future – "Thanks for being strong all those years ago".
11. Pepper your fridge with post-its. Write I CAN DO IT on the mirror.
12. Imagine you are your own best friend and give yourself some good advice.
13. Think like an athlete and get coaching and support from anywhere and everywhere you can.
14. Plan your support sessions in advance – know what you want to say or write to a friend, a group, a counsellor or a doctor.
15. Write an agenda and use it in support sessions.

These useful tips can also be supported by with the use of two Planner and Review sheets that help the person:

- i) **Plan an agenda** in order to get the most out of the subsequent support session
- ii) **Make a clear plan** about the module they will follow; the piece of reading or work they will undertake; and when they will do the work; the plan may also identify possible blocks to doing the work and how the person will address them.

Shorter practitioner/supporter tick lists and longer support scripts can be used to help the practitioner cover key parts of this 'Plan-Do-Review' process (see <http://www.fiveareas.com/resourcearea/>; Williams, 2009; Williams & Chellingsworth, 2010).

Specific role of the telephone in guided self-help and low intensity interventions

The delivery of CBT self-help interventions is rapidly changing with innovations being adopted that have the potential to enhance the accessibility, availability and cost effectiveness of mental health services. The telephone has the ability to overcome many of the social, physical and economic barriers that prevent access to mental health services, and is increasingly being used as a means to support treatment delivery (Bee et al, 2008).

Although there is evidence that users find telephone-delivered interventions acceptable (Lovell, 2006; Bee et al, 2008; Turner, 2009), some healthcare professionals are resistant to this innovation. Key concerns highlighted by healthcare professionals are focused on the belief that the lack of non-verbal cues and interpersonal contact result in a perceived loss of the therapeutic alliance (Richards et al, 2006). Although there is a paucity of research examining therapeutic alliance with recipients of telephone interventions, emerging work shows that a positive therapeutic alliance, and a level of alliance comparable with face-to-face contact, is achieved with telephone-delivered support (Lingley-Pottie & McGrath, 2007). Our experience of providing specifically tailored training for healthcare professionals in delivering telephone interventions has found an alleviation of fear and an increased receptiveness to using the telephone to support people using self-help materials.

Through our research findings and clinical experience of delivering telephone interventions we have developed some advice for enhancing support by telephone, as follows:

- All telephone calls should be scheduled, thus ensuring the person is prepared and free from interruption.
- Orientation to telephone-delivered therapy is important in establishing both engagement and collaborative working. Ensure that the person is free from interruption and has a pen and paper, copies of outcome/process measures, and the self-help books or other literature that will be used during the call.
- Users of telephone-delivered interventions have expressed a need to know more about the background and credentials of the healthcare professional than in face-to-face therapy. These findings suggest that healthcare professionals should introduce themselves and give a detailed description of their qualifications and experience. Alternatively an information sheet or podcast of the healthcare professional's credentials and their photograph can be sent before the first appointment.
- Elicit any immediate concerns from the person regarding using the telephone and encourage regular feedback from people during the first few sessions so that any concerns or fears can be discussed.
- Our experience is that many people prefer evening calls between 6.00 and 8.00 pm.
- Pauses in a telephone conversation often indicate misunderstanding, hesitation or not listening, therefore a clear explanation of pauses should be given to the person, for example: 'Throughout the call there may be a few pauses, these

silences indicate that I am thinking, or writing something down and do not mean that I don't understand or have not heard you'.

- Establish an agreed code word that the person can use if an unexpected interruption occurs. This ensures that person can put down the phone without the need for explanation and the healthcare professional can ring back at a mutually convenient time.

Internet-based tools such as instant messaging, emails or Skype (which provides free calls over the internet) can be used to provide support, as can more general support methods such as web-based forums and bulletin boards. When accessing the latter, the person can be offered hints and tips by others and be given very real encouragement. Some services are using CCBT packages that can provide a form of automated support. They can be programmed to remind and encourage the person to login, and can offer praise and encouragement when progress is made. Practitioners/supporters can also be alerted if the person's ratings worsen or risk items are ticked on review questionnaires. Such approaches usually aim to supplement and automate only part of the practitioner support –the underlying relationship with a person is still seen as key. Further guidance about both telephone and internet counselling is published by the British Association of Counselling and Psychotherapy (BACP).

In conclusion, support is crucial for helping people get the most out of CBT self-help. The support can be offered both face-to-face, by telephone or by using a range of other communication methods. In order for the intervention to be effective, the person delivering CBT self-help should act as an effective 'teacher' by focusing on motivating learning, monitoring progress and using a mix of encouragement coupled with pragmatic and specific planning to help people apply what they learn in their own lives. The aim is to help the person help themselves.

V Self-help and community engagement

Finally, the last chapter examines how self-help and low-intensity interventions can be introduced into whole communities. Community considerations include:

- promoting health and self-referral, raising community awareness, and developing marketing services
- promoting classes and information (e.g. booklets and websites) that make low-intensity interventions widely available
- developing specific strategies for 'hard to engage' sections of the community, such as working class men or people from black and minority ethnic communities.

We have chosen to illustrate these themes by referring to the STEPS service in Glasgow, which has pioneered and developed many of these approaches (White, 2008a,b; 2009; White et al. 2008). Although not an IAPT service, we believe that many aspects of STEPs could help inform the delivery of IAPT services in England and help promote the role of PWPs. It should also be noted that the evaluation of the STEPS service has been limited mainly to evaluations of its community education packages such as "Stress pack" (White, 1995;1998; 2000). However, community interventions such as STEPs do not easily lend themselves to the rigour of RCTs.

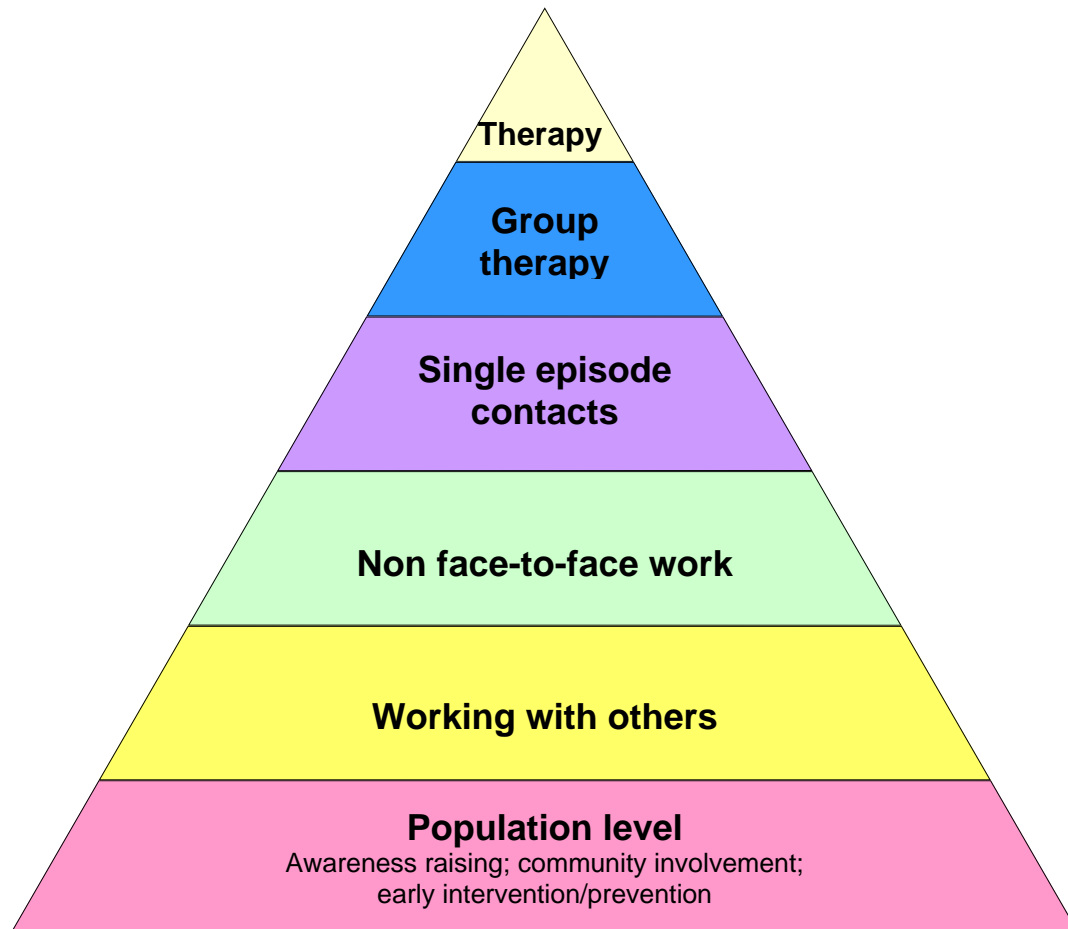
How to engage with communities in promoting self-help and resilience: the work of STEPS

The work of STEPS NHS primary care mental health team, which provides services in south east Glasgow, is a good example of how to engage with communities in promoting self-help. Working in a highly deprived city, STEPS developed services appropriate to the range of psychosocial problems familiar to any experienced clinician. STEPS, which is a Scottish Government Exemplar Project, comprises two clinical psychologists, two CBT therapists, two person-centred counsellors, two assistant psychologists, a (volunteer) 'expert patient' and a sessional exercise trainer; 1.6 workers provide administrative services. More detailed information can be found in White (2008 a,b) and White and colleagues (2008).

The most important goals of the STEPS service are as follows:

- To raise awareness of common mental health problems and to counteract stigma.
- To develop a range of self-referral services that allow STEPS to provide a very high volume service (over 3000 new contacts per year) with no waiting list for any service.
- To ensure that all therapies take into account the social realities of the person with a range of psychosocial interventions in place aiming to minimise the impact of detrimental social factors rather than necessarily attempting to 'cure' distress.

The STEPS service operates at six interactive levels:



People can work at several levels simultaneously or sequentially, for example, individual therapy followed by self-help or vice versa. This model is a variant of stepped care in that the person does not necessarily 'step up' towards individual therapy but 'step onto' the service most relevant to their needs.

Using this model allows STEPS to focus on three aspects of care:

- Interventions designed to help those already experiencing common mental health problems.
- Preventative and/or early interventions to help stop the development of common mental health problems.
- Interventions to promote well-being and resilience in communities.

In order to facilitate self-referral, comprehensive information called the *STEPS Brochure* about what the STEPS service has to offer has been widely distributed throughout the community. The brochure offers a range of self-selection services that people can access, usually by making one telephone call to a STEPS administrative worker. The brochure is widely distributed across south-east Glasgow, for example in GP waiting rooms, libraries, bowling clubs, mother-toddler groups, mosques and credit unions.

The brochure is in five parts, as follows:

Part 1: Information about stress

This section contains quotes from people describing stress; the 15 most common symptoms and four ‘quick questions’ about stress. It also has ‘Stress Control in Ten Words’ and ‘Face your fears – Be more active – Watch what you drink.’

Part 2: Steps classes

All groups meet in community settings. ‘Stress Control’ is a six session didactic CBT ‘class’ (not ‘group therapy’). ‘First Steps’ is a support group run by a peer support volunteer. ‘Connect’ is an interactive six-session social anxiety class. ‘Step into Shape’ is led by a qualified exercise trainer. ‘Mood Matters’ is a six-session interactive approach focusing on depression. STEPS are testing both CBT and behavioural activation versions. ‘LifeGym’ involves modified Wellness Recovery Action Planning; local community groups are currently being trained to use LifeGym to allow it to be widely disseminated.

Part 3: Therapist contact services

Access to individual therapy mainly comes via the ‘Call-Back’ service, where individuals leave basic contact details and a therapist calls them back (on average, 9.6 hours after the person calls), carrying out a protocol-based assessment. People enter a STEPS service, on average, 9 days after the call back. The Advice Clinic offers a 30-minute afternoon appointment with a therapist or assistant psychologist. Most people can be given an appointment within the week of phoning. STEPS also runs a rolling programme of workshops/events; examples include: ‘Just had a baby?’, ‘Assertiveness’ and ‘Work Stress’.

Part 4: Other STEPS services

STEPS has set-up dedicated mental health sections (‘Healthy Reading’) in all thirty four Glasgow libraries, purchasing evidence-based (mainly) CBT self-help books. The ‘Steps out of Stress’ series currently contains 22 self-help guides to common problems written by the team. On the website www.glasgowsteps.com, three main interconnected sections centre around the ‘Stress Wheel’ – an information section, an assessment section with 12 interactive questionnaires, and a self-help section offering CBT options for a range of common problems. The site has video, audio, relaxation and booklet downloads. Having the Glasgow-wide service directory online (www.glasgowhelp.com) allows STEPS to keep it up-to-date. Information in Urdu is available for the large Pakistani

population in south-east Glasgow. Also linked to the website, users can sign up via iTunes for STEPS podcasts (called STEPS sounds).

STEPS has also produced a range of DVDS, including '100 people', which looks at how common 'stress' is and suggests some straightforward ways to prevent and tackle it. It is part of a school anti-stigma project. 'Everything you always wanted to know about stress (but were afraid to ask)' is particularly aimed at more deprived areas and has been distributed to around 100,000 NHS, social work and Strathclyde Police employees. Both DVDs can be seen on the STEPS website and on YouTube.

Part 5: Other services

This section contains information about other local service providers and useful websites.

Other STEPS activities have included the distribution of 20,000 copies of a booklet called 'Controlling your Stress' about mixed anxiety and depression to GPs and partner organisations. Thirty thousand 'Getting the best out of your anti-depressants' booklets have been delivered to all Glasgow GPs and community pharmacists. Similarly, STEPS offers training to GPs and other primary care staff to help improve detection of depression and offer alternatives to prescribing antidepressants. The 'Coping with Trauma' and 'Coping with Panic Attacks' booklets are used by the local A&E department and Victim Support. STEPS has also developed a training package in basic CBT strategies for other primary care staff, social workers and voluntary organisations.

In order to enhance the presence of the service within the community, STEPS workers and volunteers regularly run stalls at community fairs, carers' events, schools and supermarkets offering copies of booklets, DVDs and sign-ups for STEPS services. 'Laff yer heid aff' (Laugh your head off; Jamieson et al., 2008), a stand-up comedy event on the theme of mental health has run over the last 2 years as part of the Scottish Mental Health Arts and Film Festival. STEPS has also developed an interactive event for senior pupils in all south-east Glasgow secondary schools based around the themes in the '100 people' DVD.

In conclusion, STEPS offers a wide-ranging psychosocial service relevant to a deprived area. Evaluation (White 2008 a,b; White et al. 2008) is generally positive, with GPs particularly satisfied about the range of STEPS services and their easy accessibility. STEPS are now focusing on 'hard to reach' populations.

V Conclusions and recommendations

Although there is now extensive evidence to support the importance of guided self-help as a critical component of low-intensity interventions, it is also apparent that the superficially simple act of handing a the person information about their psychological problem and how they might best cope or manage may not be as simple as things would first seem. PWP's and therapists intending to use self-help information should consider several key principles before embarking on this approach:

1. Whenever possible, self-help information and the *approaches* upon which it is based should be supported by the evidence base. It shouldn't be assumed that self-help materials will be of benefit to *all* individuals and for *all* psychological problems. Indeed, for some disorders (for example, PTSD) self-help information may be of limited value for those in distress and more intensive forms of psychological therapy should be sought.
2. Generally, self-help information should be based around CBT principles and approaches.
3. Information alone is seldom effective, and the PWP or therapist will need to consider how they can support or guide the person to use the materials effectively. How materials are structured and how patients are motivated/empowered to take responsibility for their condition are all important factors.
4. Self-help materials should be selected to meet the individuals' needs, in terms of their problems and goals, taking into account factors such as the stage of the intervention, literacy skills and cultural considerations.
5. Information should be available in a range of modalities (leaflets, books, DVDs, web-based) and should be accessible to people irrespective of the degree of education, disability, language or culture.
6. People should be aware of the availability of different self-help materials and services, and able to make informed choices about the type of materials that they wish to use.
7. When self-help or low-intensity interventions have been insufficient to meet the person's needs, they ought to be stepped up to a more intensive form of treatment.

We trust that the guidance in this will be helpful for PWP and other staff working within IAPT services. We also believe that it could be useful to other psychological therapists working elsewhere in healthcare services and to other primary care workers and healthcare support workers such as health trainers. We would welcome any feedback and please feel free to send comments to g.turpin@shef.ac.uk.

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Annex 1

Contributing authors and presenters at the IAPT Self-help Conference, Leeds, February, 2009.

Clare Baguley – University of Manchester

Paul Farrand – University of Exeter

Roslyn Hope – NIMHE

Judy Leibowitz – Camden PCT

Karina Lovell – University of Manchester

Mike Lucock – University of Huddersfield

Catherine O'Neill – Anxiety UK

Roger Paxton – Northumberland, Tyne and Wear NHS Trusts

Stephen Pilling – University College London

Dave Richards – University of Exeter

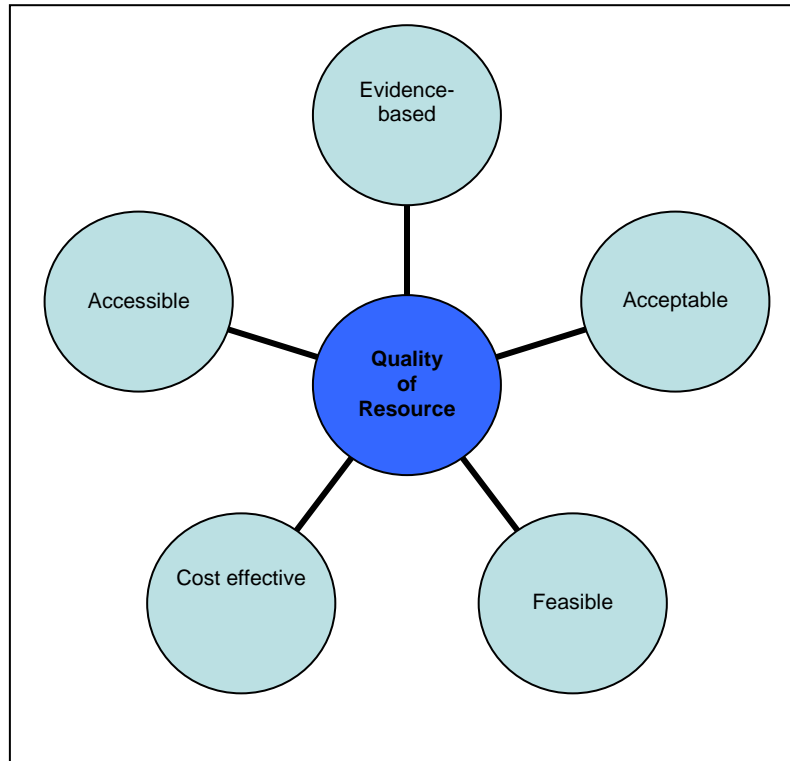
Graham Turpin – University of Sheffield

Jim White - NHS Greater Glasgow & Clyde

Chris Williams – University of Glasgow

Annex II

A Quality Standards Framework for Assessing Self-Help Materials (University of Manchester)



These criteria can be applied to all types of resources on the continuum of self-help provision. It allows for consideration of a range of models and modes of delivery, and can be used by both people and practitioners to critically appraise materials. Importantly it encourages the reviewer to consider issues of evidence against subjective considerations such as accessibility and cost.

Criteria 1: Evidence-based

- Is the resource material underpinned by an evidence-based model (i.e. CBT)?
- Is this clearly explained in understandable language?
- Does it include examples of lived experience?
- Does the resource material incorporate self-rating and measurement to help the person monitor their progress and to learn about what helps?

Criteria 2: Acceptable

- Is the manner of presentation and mode of delivery likely to be used by the target group / person?
- Does it take into account individual and cultural variation?

Criteria 3: Feasible

- Taking into account both personal and practical resources, are the target group / person likely to be able to make use of the resource material?
- Can the practitioner / service appropriately support the use of the resource material?

Criteria 4: Accessible

- Does the target group / individual have the means to access the resource material on a regular basis?
- Is the service able to ensure appropriate respect for confidentiality and support needs?
- Is the resource material available in a range of languages / translatable?

Criteria 5: Cost effective

- How will the resource material be financed?
- Does the evidence for effectiveness match the costs?
- Is the resource material value for money?

One way to understand the materials you are going to use, is to allocate time to find and systematically review them. The following can be used as an individual or group exercise:

- Seek out as wide a range of resources as possible, with an example of every of mode of delivery (for example, reading materials, web-based resources, computer programmes, and so on).
- Examine each resource against the five quality criteria above.
- Rate each resource giving it a score of 0 - 8 for each quality criteria depending whether it meets all or none of the criteria.
- Add the scores together and divide by 5 to assign each resource a total score.
- Rank the resources identifying their strengths and weaknesses.
- Plan what would need to happen to implement the highest ranking resources.

Used in small groups this exercise will encourage critical appraisal of the resource and objective consideration of issues of implementation. The person can also contribute to informed decision making about the use of a particular resource. Nevertheless, we would not wish to encourage the selection of self-help materials based merely on the widespread ranking of materials.