The Value of Digitally Supported Evidence-Based Step Psychological Interventions in Northern Ireland

A policy and practice brief
November 2025

Prepared by
Dr Enya Redican, Ulster University
Dr Colin Gorman, Ulster University & Pneuma Healthcare
Dr Orla McDevitt Petrovic, Ulster University
Prof Maurice Mulvenna, Ulster University & Pneuma Healthcare
Professor Karen Kirby, Ulster University
Dr Donal McAteer, Ulster University

ulster.ac.uk

1. EXECUTIVE SUMMARY

Northern Ireland (NI) should establish a **centralised Step 2 Low Intensity Cognitive Behavioural Therapy (LICBT) Hub**, sustainably funded and equipped to deliver high-volume, digitally enabled, and routinely monitored psychological interventions. Such a hub, for a modest investment would represent a transformative investment in early intervention, ease demand on overstretched specialist services, align NI with international best practice, and position NI as a leader in mental health innovation.

NI already has the human, digital and organisational capacity to achieve this. Pneuma Healthcare, a spin-out from Ulster University, currently delivers over 25,000 sessions annually to Talking Therapies for Anxiety and Depression (previously Improving Access to Psychological Therapies [IAPT]) Services in England, using videoconferencing, telephone, supported e-therapy and online group format. Practitioners in this company are primarily sourced from a well-established and accredited clinical training programme at Ulster University, which has been producing these skilled graduates for the past ten years. Therefore, the infrastructure and expertise are in place to deliver evidence-based Step 2 interventions at scale in NI, directly advancing the objectives of the NI Mental Health Strategy 2021 – 2023[1] and the Programme for Government 2024 – 2027[2].

This brief sets out the case for a Step 2 LI-CBT Hub in NI, outlining the Stepped Care Model, the need for Step 2 services, evidence of their efficacy, and alignment with strategic priorities.

2. INTRODUCTION

Northern Ireland (NI) faces a persistent mental health crisis. Prevalence rates of mental disorders are approximately 25% higher than in other parts of the UK[3], with depression and anxiety affecting one in four adults in NI[4]. Many of these mental health conditions begin early in life: one in eight young people in NI meet diagnostic criteria for anxiety or depression[5]. Reflecting the severity of this crisis, NI also reported the highest suicide rates in the UK in 2023, with 13.3 deaths per 100,000 population[6]. This stark situation reflects a complex interplay of factors, including the legacy of the Troubles, persistent socioeconomic deprivation, the COVID-19 pandemic, and chronic underinvestment in mental health services[7-8]. The economic burden is equally severe, costing the NI economy at least £3.4 billion annually[8]. Despite this, access to psychological therapies remains critically limited, with NI mental health services consistently underfunded compared to other UK regions[9]. Urgent investment in clinically effective, financially sustainable interventions is essential. Establishing a centralised Step 2 LI-CBT hub in NI, where qualified Psychological Wellbeing Practitioners (PWPs) deliver therapies at scale, offers a timely and cost-effective opportunity to reduce unmet need, relieve pressure on overstretched services, and improve population mental health.

3. THE STEPPED CARE MODEL

What is the Stepped Care Model?

The Stepped Care Model, recommended by the National Institute for Clinical Excellence (NICE)[10], structures treatment by intensity to improve service efficiency and ensure patients access timely, effective, evidence-based care. Treatments are structured in a hierarchy from low to high intensity. The least intensive step is offered first, with patients stepped up if they do not recover, present with more severe symptoms, or have specific disorders where low intensity interventions are not recommended such as posttraumatic stress disorder and social anxiety. The Stepped Care Model is self-correcting in that patients can be stepped up or stepped down at any time. This is made possible by routine monitoring of patient progress, which includes their responsiveness to

treatment, symptom severity, and changes in risk or need [11]. The stepped care model is highly effective at the patient level by improving their mental health; and alleviating burden at the service level through increasing throughput; and at the economic level by reducing disability-adjusted life years (DALYs), productivity losses from work absence, personal time costs, and healthcare expenses[11-13].

The Stepped Care Model in NI

The groundbreaking Bamford Review[14] provided compelling evidence for embedding the Stepped Care Model within mental health services in NI. The subsequent Bamford Action Plan[15] identified implementation of the model as a key priority to improve early intervention and access to psychological therapies. Since then, progress has been made, with the Care Pathway for delivery of mental health services in NI explicitly adhering to the Stepped Care Model[16]. However, challenges remain. Service provision continues to centre largely on secondary care (Step 3 onwards), reflecting the greater emphasis on treating more complex mental health difficulties in NI[17]. Additionally, resource constraints, chronic underinvestment, and rising demand for support[18] have resulted in deprioritisation of full implementation of the model. This is particularly evident at Step 2, which serves as the main entry into mental health services, and whose effectiveness and efficiency have a compounding downstream impact on subsequent levels of service delivery. Although Step 2 services exist in NI, delivery remains fragmented. A co-ordinated, system-wide approach is therefore required to ensure uniform delivery of these interventions, alongside robust data collection and evidence generation across the region. This need is especially timely given that the NI Mental Health Strategy 2021–2031[1] calls for expansion of psychological service provision across both primary and secondary care to ensure that **all steps** of the stepped care model are implemented.

Step 2 Interventions

In line with NICE guidance[19-20], Step 2 interventions are recommended as a first line treatment for people with mild to moderate depression or anxiety disorders including generalized anxiety disorder, panic disorder, and obsessive-compulsive disorder. Treatments at Step 2 can include guided self-help based on CBT principles (i.e., LICBT), computerised CBT programmes, psychoeducational groups, and structured group physical activity. Of these treatments, LICBT is recommended as the first choice, as it is the least intrusive and resource intensive option. NICE guidelines for mild-to-moderate depression and anxiety recommend that LICBT is delivered using structured self-help materials, supported by a trained practitioner. It should involve 6 to 8 30 minute sessions for depression and 5 to 7 30 minute sessions for anxiety, all of which can be delivered remotely. Step 2 LICBT interventions have low financial and time costs for patients, clinicians, and mental health services[21], and many people with mild to moderate depression or anxiety are likely to benefit from this treatment[12].

4. STEP 2 LICBT IN PRACTICE

The NHS Talking Therapies Model

Since 2008, LICBT has been a central component of the adult NHS Talking Therapies Programme in England. This world leading programme has some of its roots in lessons learned from the NI Troubles, where a group of international experts convened to provide guidance on addressing the mental health impact of the 1998 Omagh bombing. The NHS Talking Therapies programme was

established to expand access to evidence-based psychological treatments and to promote economic prosperity by increasing the likelihood of patients recovering and returning to work[22]. All services offered through this programme are designed based on NICE guidelines, with LICBT is provided as a Step 2 intervention for mild to moderate depression and anxiety. While this approach that was born in Northern Ireland has been adopted worldwide, we are yet to experience the benefits!!

The LICBT model & its benefits

LICBT is a type of cognitive behavioural therapy (CBT), delivered by trained PWPs, that uses guided self-help to support patients with mild to moderate depression and/or anxiety symptoms. Interventions include cognitive restructuring, behavioural activation, exposure and habituation, worry management, medication management, problem solving, and sleep hygiene, all of which focus on equipping patients with the skills necessary to manage their symptoms. Treatment typically includes 6 to 8 sessions, each lasting 30 minutes, and delivered through face-to-face, telephone, or digital platforms. Patient symptom severity is measured at the initial assessment and at every session thereafter using the PHQ-9[23] (measures major depressive disorder) and the GAD-7[24] (measures generalized anxiety disorder). The PHQ-9 and GAD-7 are used across all Talking Therapies services, supporting national comparisons in the efficacy of Step 2 interventions. Improvement in symptoms is determined using a reliable change index where reductions of six points in PHQ-9 scores and reductions of four points in GAD-7 scores indicate reliable improvement in depression and anxiety symptoms, respectively. Reliable recovery requires demonstration of reliable improvement and scores at the end of treatment being below clinical thresholds.

The LICBT model has many benefits, including:

1. **Strong economic and societal return**
   Using the savings outlined in the Layard report on the economic impact of LICBT[25] as a reference point[1], and adjusting these figures for inflation over the past 19 years (approximately 73.8% as of September 2025) [26], a typical course of treatment costs around £1,390, yet generates estimated benefits of £2,085.54 in additional GDP within two years, £964.70 in NHS savings, and approximately £5,736.07 in monetised wellbeing improvements. Wider benefits include reduced incapacity benefit payments, increased labour market participation and reduced reoffending[27].
2. **Proven clinical effectiveness**
   Evidence from over 100 studies using data from UK-based NHS Talking Therapy Services confirms its effectiveness in reducing symptoms of depression and anxiety[28]. Recent data from 2023 – 2024[29] indicates that 26 million people accessed NHS Talking Therapies during this period, with 90.5% seen within 6 weeks, 47.1% of those who completed treatment achieving reliable recovery and 66.8% achieving reliable improvement.
3. **Digital delivery is as effective as face to face, with quicker access and shorter treatment duration**
   Remote delivery via videoconferencing and telephone has been shown to perform comparably to face to face treatment[30-33]. During the COVID-19 pandemic, IAPT experienced higher recovery rates and fewer cancellations[34], and shorter durations between referral and first appointment and from service entry to treatment completion[35].

[1] According to the Layard Report published by the London School of Economics in 2006, a typical course of treatment then generated treatment costs of approximately £750 yet generated estimated benefits of £1,200 in additional GPD, £300 in NHS savings, and £3,300 in monetized wellbeing improvements.

4. **Digital delivery increases accessibility for geographically remote and underserved populations**
   LICBT's flexible delivery approaches is more accessible for groups who face systematic disadvantage in accessing and receiving mainstream mental health support such as people living in rural areas[36], those with a neurodevelopmental condition[37] or learning disability[38], older adults[39], unpaid carers[40], individuals with specific mental health conditions (e.g., agoraphobia, panic disorder)[41], and individuals with complex disabilities[42], among others. Digital delivery removes barriers associated with accessing in-person care for these groups, including transportation difficulties, inaccessible office environments, limited time, and competing demands[43].
5. **Low-Intensity, high volume delivery**
   NHS Talking Therapy programmes treat over 960,000 patients per year in England[44], with PWPs typically managing caseloads of more than 250 clients annually. This ensures that PWPs can treat more patients in less time. In NI, approximately one in four adults experience a common mental health problem, which – based on the 2021 Census estimated population size – equates to approximately 308,200 adults. Although no data exists in NI relating to how many of these cases are mild to moderate, international estimates indicate that ~78% of disorders are classified as mild or moderate[45]. Therefore, the LICBT model could facilitate the recovery of ~240,396 adults in NI.
6. **Improved efficiency of mental health services**
   By offering early intervention, LICBT prevents mental health problems from escalating and requiring more intensive and expensive treatments at a later stage. Evidence from NHS Talking Therapies indicates that only 4.1% of patients who begin at Step 2 are stepped up to more intensive treatments[46]. This demonstrates how successful treatment at the first point of contact removes the patient from the system and thus reduces pressures on other mental and physical health services including general practitioners (GPs), accident and emergency (A&E), specialist mental health services, psychiatric inpatient clinics, crisis services and the community and voluntary sector.
7. **Delivery by specialist workforce maximises treatment benefits**
   LICBT is delivered by PWPs trained specifically in techniques for treating mild to moderate depression and anxiety disorders. Their targeted training covers psychological assessment, delivery of low-intensity interventions, collection of clinical outcome measures, and delivery across multiple modalities, all within short 30-to-40-minute sessions and at high caseload volumes. This contrasts with high-intensity therapists, who work with more complex presentations in longer sessions, resulting in smaller caseloads and a broader range of therapeutic techniques. Using PWPs to deliver LICBT is more cost-effective and clinically sensible, enabling high-intensity practitioners to focus on the delivery of Step 3 interventions that require their advanced training and expertise.
8. **Adapted LICBT programmes improve mental health and reduce costs for specialist groups**
   The IAPT Long Term Conditions (IAPT-LTC) programme provides Step 2 interventions for individuals with long term physical health conditions and medically unexplained symptoms (MUS)[47]. Research has shown how LICBT can be effective in treating psychologically distressing MUS[48] and can significantly reduce healthcare costs which are typically 50% higher for those with a LTC who have co-occurring depression or anxiety symptoms[44]. Similar adapted Step 2 interventions are available for women in the perinatal period, where mild-to-moderate depression and anxiety are common[49].
9. **Routine data collection increases quality and cost-effectiveness of service delivery**

A fundamental feature of Step 2 LICBT interventions is the routine collection of data on patient and service characteristics, and treatment outcomes. This has multiple benefits, including (1) monitoring and removing barriers to service access, (2) ensuring fidelity to NICE guidelines, (3) supporting identification of appropriate and effective interventions, (4) increasing patient awareness of progress, (5) determining whether patients need to be 'stepped-up' to more intensive treatments, (6) supporting PWPs in their clinical supervision sessions, and (7) improving the quality and cost-effectiveness of services[12].

5. MODELLING THE SUCCESS OF NHS TALKING THERAPIES IN NI

Ulster University MSc Applied Psychology (Mental Health & Psychological Therapies)

In 2015, Ulster University began training psychology graduates to become qualified PWPs in NI through their MSc Applied Psychology (Mental Health & Psychological Therapies) Programme. To date, over 140 PWPs have been trained, each completing a minimum of 80 hours of direct clinical contact and delivering thousands of LICBT sessions across primary care and community care settings in NI, including within GP practices, universities and in the community and voluntary sector. Given that a typical course of treatment costs approximately £1390, the voluntary provision of LICBT by trainee PWPs in NI over the past decade has generated an estimated cost saving of £2.92 million (based on 140 PWPs treating 15 clients each at £1,390 per treatment) to the NI economy. However, the absence of a fully commissioned PWP service in NI has limited the scale of LICBT provision. Up until recent years any highly skilled, MSc-qualified, and British Psychological Society (BPS) accredited graduates have left NI to work in regions where LICBT services are well-established and funded.

Evidence from Ulster University Trainee PWPs

Data collected from trainee PWPs at Ulster University has enabled the generation of the following evidence:

Study	Setting	Key findings	Key Implication
Modelling changes in depression and anxiety[50]	253 patients referred to 29 trainee PWPs across GP practices, NHS Trust sites, and community organisations between 2015 and 2017.	• 82.8% showed improved anxiety symptoms • 87.3% showed improved depression symptoms • Non-improvement associated with unemployment, chronic symptoms (5+ years), suicide risk, comorbidities, using medication, or concurrent treatment	Strong symptom improvement from LICBT delivered by trainee PWPs.

LICBT in Primary and Community Care Settings[51]	163 patients receiving LICBT via primary and community care settings across NI between January and June 2016.	• 47.9% achieved recovery • 76.7% showed reliable symptom improvements • Only 6.1% showed deterioration in symptoms • Reliable improvement rates higher in NI (76.7%) than England (62.2%)	LICBT in NI produces outcomes that compare favourably with those in England, supporting its local effectiveness.
Your Emotional Wellbeing (YEW) Project[52]	2533 LICBT sessions delivered by 2 PWPs via a programme developed by Action Mental Health in collaboration with UU.	• 85% of individuals showed improved depression symptoms • 91% of individuals showed improved anxiety symptoms • Many moved from clinical to non-clinical for both depression and anxiety	Embedding LICBT provision within community and outreach settings leads to significant improvements in symptoms.

Establishment of Pneuma Healthcare

Recognizing the need for service development in NI, Dr Colin Gorman (Lecturer in Clinical Psychology, Ulster University) founded Pneuma Healthcare in 2022 as a spin-out company of Ulster University. Pneuma employs locally trained PWPs to deliver LICBT across NHS, private, community, voluntary, and corporate sectors. Services are delivered remotely via telephone and videoconferencing and are supported by Pneuma's Virtual Integrated Model (VIM). This model enables PWPs to be fully embedded within their host teams while receiving structured support from Pneuma's central team. Pneuma, a collaboration between Schools of Psychology and Computing at UU, (Professor Maurice Mulvenna) utilises digital innovation to enable high-quality data collection and analysis, ensuring that the organization consistently operates in an evidence-informed manner. Although the majority of Pneuma's current service users are based in England, it has the clinical expertise and workforce capacity to deliver LICBT at scale within NI, contingent on appropriate investment and commissioning.

Evidence from Pneuma Healthcare's Qualified PWPs

Since 2022, Pneuma Healthcare have been providing remote LI-CBT to NHS England Talking Therapy services. The data collected throughout this period has enabled the generation of the following evidence:

Indicator of effectiveness	Evidence	Key Implication
Establishment of workforce	45 graduates have been retained in NI	Pneuma Healthcare has boosted the NI economy and prevented 'brain drain' of mental health practitioners.
Digital capacity	Pneuma has provided triage assessments, LI-CBT supported Silvercloud, and online group psychoeducation and support remote services to several Trusts in England including Greater Manchester Mental Health Service (GMMH) who service a population of 2.8 million. Services have been provided across five locations (Bolton, Wigan, Trafford, Salford and Manchester Central), while based in NI.	The digital infrastructure developed by Pneuma has enabled effective remote delivery of LICBT and other Step 2 interventions in other UK regions.
LICBT provision at scale	PWPs have provided over 60,000 treatment sessions to more than 10,000 people in GMMH. Clients are usually seen within two weeks of initial contact with services and treatment started with 4 weeks. Each clinician provides over 2,000 sessions of either LI-CBT, supported e-therapy or online group psychoeducation, resulting in 340 episodes of care per PWP per year.	45 PWPs in NI have delivered Step 2 interventions in high-volume, timely, efficient manner.
Performance against national benchmarks	Pneuma PWPs have exceeded 'IAPT' benchmark rates for recovery and significant improvement, with 54% of those with clinical levels of depression and anxiety treated reaching full recovery, and 76% making a significant clinical improvement.	PWPs in NI are delivering remote LICBT interventions more effective and efficient than national benchmarks.
Routine data collection	The PHQ-9 and GAD-7 are completed in all sessions, ensuring availability of data for analysis at therapist, service, or clinical presentation level. For example, research conducted within UU on the GMMH data shows minimal differences in outcomes between face-to-face, online and telephone sessions, with telephone being slightly less effective.	Pneuma is committed to routine data collection to ensure effective and appropriate interventions.
Digital Integration	Pneuma are using digital platforms that are designed for seamless integration with existing Northern Ireland Health and Social Care (HSC) digital infrastructure. This compatibility means they can be rapidly scaled and embedded within current systems to extend reach and improve service delivery, without the need for major technical redevelopment or costly system overhauls. Such an approach supports a data-driven, cross-jurisdictional model of care aligned with the Department of Health's	Pneuma's platform integrates easily with HSC systems, allowing scalable, data-driven service delivery.

strategic priorities for innovation, digital transformation, and performance accountability across the mental health sector. There is clear evidence that digital interventions when they are 'therapist-guided' have better accessibility, engagement and outcomes[53].

STRATEGIC POLICY ALIGNMENT

Pneuma Healthcare and Ulster University provide strong local evidence for the effectiveness and efficiency of LICBT, underscoring the need for a centralised Step 2 LICBT hub to deliver high-volume, digitally enabled, and routinely monitored psychological interventions. Establishing such a transformative initiative in NI aligns clearly with key objectives outlined in the Mental Health Strategy for NI and the Programme for Government, along with guidance from other governing bodies such as the British Psychological Society.

Mental Health Strategy for Northern Ireland (2021 – 2031)[1]

- **Actions 5 & 15 – Early Intervention & Community Mental Health:** Establishing a centralised Step 2 LICBT hub that provides services to primary care and community settings would directly support the Strategy's goal of providing accessible, early intervention to as many people as possible.
- **Action 19 – Psychological Therapies:** Establishing a centralised Step 2 LICBT hub ensures a coordinated, system-wide approach that supports the Strategy's objective to deliver care across all steps of the stepped-care model.
- **Action 30 – Digital Mental Health:** Establishing a centralised Step 2 LICBT hub that delivers fully remote services via videoconferencing, telephone, and evidence-based e-therapy programmes such as Silvercloud ensures the Strategy's recommendation of digital mental health provision is realised.

Programme for Government (PfG) 2024 – 2027[2]

- **Action 32 – Workforce for the future:** Establishing a centralised Step 2 LICBT hub would require the formal establishment of the PWP role in NI, directly supporting the Strategy's objective of developing a new workforce.
- **Grow a Globally Competitive and Sustainable Economy:** Establishing a centralised Step 2 LICBT hub would create high-quality employment opportunities for qualified PWPs, directly supporting the PfG's objective of improving job quality, productivity, economic growth and innovation.

NI British Psychological Society's Recommendations[54]

- **Cut Health Waiting Times:** Establishing a centralised Step 2 LICBT hub ensures a high input and throughput of patients, addressing the PfG's goal of reducing health waiting times in the region.
- **Psychological Workforce:** Establishing a centralised Step 2 LICBT hub that recruits psychology graduates with PWP qualifications addresses NIBPS's recommendation of increasing alignment between mental health services in NI and the wider UK, while also helping to close workforce gaps.

- **Digital Mental Health** (*see Mental Health Strategy section)*
- **Support for physical health-related mental health problems:** Establishing a centralised Step 2 LICBT hub addresses this recommendation by providing adapted programmes for individuals experiencing mild to moderate depression or anxiety linked to chronic health conditions or the perinatal period.

POLICY & PRACTICE RECOMMENDATIONS

1. Commission digital LICBT services at scale across NI

NI should establish a centralised Step 2 LICBT hub which provides digital Step 2 LICBT interventions at scale across NI. As a first step to achieving this and ensuring that action is taken now to address NI's mental health crisis, we recommend that a regional LICBT pilot programme is commissioned. The infrastructure, knowledge base, and experience are already in place via Pneuma Healthcare to deliver these services. Therefore it would be possible for £600,000 to deliver 1,600 LICBT treatment episodes (10,000 sessions) within one year which would make a significant impact on the mental health landscape in NI.

2. Formalise the PWP role within the NI workforce

2A. Address workforce shortages and retain local talent

Despite a shortage of professionals in many areas of mental health in NI, including psychiatrists[55], mental health nurses[8], and clinical psychologists[56], psychology graduates are often an underused resource[56]. Each year, there are approximately 550 psychology graduates in NI with limited career opportunities. Establishing a centralised Step 2 LICBT hub that employs psychology graduates with PWP qualifications would retain this workforce, prevent the ongoing 'brain drain' of mental health practitioners, enable more effective delivery of the stepped-care model, and achieve significant cost savings for the health service since PWPs are employed at NHS Agenda for Change Band 5.

2B. Ensure quality and efficiency in service delivery

Delivery of NICE-recommended care depends on the right workforce, appropriately trained and with the capacity and skills to deliver these interventions effectively[12]. Service audits have found that some high intensity therapists may be providing low-intensity interventions without specific LICBT training[57]. Establishing a centralised Step 2 LICBT hub in NI ensures that PWPs deliver these services.

Conclusion

Establishing a centralised Step 2 LICBT hub in NI would significantly increase access to psychological therapies, reduce mental health waiting times and pressure on existing services, and align provision with international best practice, while also delivering significant cost savings. Beyond these benefits, it offers a unique opportunity to transform the mental health system in NI and beyond. NI is already home to world-leading expertise, with researchers at Ulster University, Queens University Belfast, and the Impact Research Centre, producing internationally recognised evidence on mental health issues. For example, researchers at UU developed the International Trauma Questionnaire, now used internationally to assess trauma-related disorders[58]; produced research on suicide deaths and unique features of suicidal behaviour in NI that shaped NI's suicide

prevention strategies[59]; and developed novel applications of machine learning that have enhanced the design and delivery of mental health services[60]. A hub could harness this wealth of expertise, acting as a conduit between cutting-edge research and service delivery, ensuring NI becomes a world-leading model for translating research evidence into practice for the benefit of the population.

Further Reading

1. Department of Health. (2020). *Mental Health Strategy 2021-2023.* Department of Health . https://www.health-ni.gov.uk/publications /mental-health-strategy-2021-2031
2. Northern Ireland Executive. (2025, February 28). Programme for Government 2024-2027 “Our Plan: Doing What Matters Most.” Northern Ireland Executive. https://www.northernireland.gov.uk/articles/programme-government-2024-2027-our-plan-doing-what-matters-most
3. Office for Statistics Regulation. (2021). *Systemic Review Programme Review of mental health statistics in Northern Ireland*. https://osr.statisticsauthority.gov.uk/ wp-content/uploads/2021/09/Review-of-mental-health-statistics-in-Northern-Ireland.pdf
4. Department of Health . (2020). Health Survey (NI) First Results 2019/20. https://www.health-ni.gov.uk/sites/default/files/publications/health/hsni-first-results-19-20.pdf
5. Bunting, L., McCartan, C., Davidson, G., Grant, A., McBride, O., Mulholland, C. … Shevlin, M. (2020). *The Mental Health of Children and Parents in Northern Ireland.* Belfast: Health & Social Care Board
6. Northern Ireland Statistics and Research Agency. (2025, February 3). *Northern Ireland Suicide Statistics*, *2023*. https://www.nisra.gov.uk/news/northern-ireland-suicide-statistics-2023
7. O'Neill, S., & Rooney, N. (2018). Mental health in Northern Ireland: an urgent situation. *The Lancet Psychiatry*, 5(12), 965–966. https://doi.org/ 10.1016/S2215-0366(18)30392-4.
8. Northern Ireland Audit Office. (2023). *General Mental Health Services in Northern Ireland.* https://www.niauditoffice.gov.uk/files/niauditoffice/documents/2023-05/00293490%20-%20Mental%20Health%20Report_WEB.pdf
9. Betts, J., & Thompson, J. (2017). *Mental health in Northern Ireland: Overview, strategies, policies, care pathways, CAMHS and barriers to accessing services* (Research and Information Service Research Paper). Northern Ireland Assembly. https://www.niassembly.gov.uk/ globalassets/documents/raise/publications/2016-2021/2017/health/0817.pdf
10. National Institute for Health and Care Excellence. (2009). Depression in adults with a chronic physical health problem: Recognition and management (CG91). https://www.nice.org.uk/guidance/cg91/chapter/Recommendations
11. Jeitani, A., Fahey, P. P., Gascoigne, M., Darnal, A., & Lim, D. (2024). Effectiveness of stepped care for mental health disorders: An umbrella review of meta-analyses. Personalized Medicine in Psychiatry, 47, https://doi.org/ 10.1016/ j.pmip.2024.100140.
12. NHS. (2018). *The Improving Access to Psychological Therapies Manual*. https://www.rcpsych.ac.uk/docs/default-
35. Capobianco, L., Verbist, I., Heal, C., Huey, D., & Wells, A. (2023). Improving access to psychological therapies: Analysis of effects associated with remote provision during COVID-19. British Journal of Clinical Psychology, 62(1), 312-324. https://doi.org/ 10.1111/bjc.12410
36. Samaritans. (2022.) People living in rural Northern Ireland least likely to see emotional support when struggling to cope. https://www.samaritans.org/ news/people-living-in-rural-northernireland-least-likely-to-see-emotionalsupport-when-struggling-to-copesamaritans-survey-finds
37. Autism NI. (2023). *Mental Health Services in Northern Ireland Failing Autistic People.* https://autismni.org/news/mental-health-services-in-northern-ireland-failing-autistic-people
38. Webb, M. A. (2019). Treat me well: Equal access to healthcare for people with a learning disability. MENCAP. https://northernireland.mencap.org.uk/sites/default/files/2019-10/Mencap%20%E2%80%98 Treat%20Me%20Well%E2%80%99%20report%20on%20health%20inequalities%20Oct%2019.pdf
39. Iskander-Reynolds, A. (2024). Mental Health in Later Life. AGE UK, Centre for Mental Health . https://www.ageuk.org.uk/siteassets/documents/professionals/mental-health-hub/centreformh-mentalhealthinlaterlife.pdf
40. Carers NI. (2023). State of Caring 2023. https://www.carersuk.org/media/xgwlj0gn/soc23-health-report_web.pdf
41. Bouchard, S., Allard, M., Robillard, G., Dumoulin, S., Guitard, T., Loranger, C., ... & Corno, G. (2020). Videoconferencing psychotherapy for panic disorder and agoraphobia: Outcome and treatment processes from a non-randomized non-inferiority trial. *Frontiers in Psychology*, 11, 2164. https://doi.org/10.3389/ fpsyg.2020.02164
42. Sense. (2023). *Access to healthcare for people with complex disabilities.* https://www.sense.org.uk/about-us/research/potential-and-possibility-research/potential-and-possibility-2023/access-to-healthcare/
43. Bond, R. R., Mulvenna, M. D., Potts, C., et al. (2023). Digital transformation of mental health services. NPJ Mental Health Research, 2, 13. https://doi.org/10.1038/s44184-023-00033-y
44. Clark D. M. (2018). Realizing the Mass Public Benefit of Evidence-Based Psychological Therapies: The IAPT Program. *Annual Review of Clinical Psychology*, 14, 159–183. https://doi.org/10.1146/annurev-clinpsy-050817-084833
45. Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005a). Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 617–627. https://doi.org/10.1001/archpsyc.62.6.617

source/improving-care/nccmh/iapt/the-iapt-manual-v6.pdf?sfvrsn=79ece7e5_2

13. Mareya, S., Watts, M. C., Zhao, L., & Olasoji, M. (2024). Exploring the Stepped Care Model in Delivering Primary Mental Health Services-A Scoping Review. International journal of mental health nursing, 33(6), 2026–2042. https://doi.org/10.1111/inm.13427
14. Department of Health.(2007). *The Bamford Review OF Mental Health AND Learning Disability (Northern Ireland): A Comprehensive Legislative Framework.*
15. Department of Health. (2012). *Bamford action plan (2012-15).*
16. Health and Social Care. (2014). *"You in MIND" Promoting Hope Opportunity and Personal Control Regional Mental Health Care Pathway*.
17. Kirby, K., McDevitt-Petrovic, O., McBride, O., Shevlin, M., McAteer, D., Gorman, J., & Murphy, J. (2017). A new mental health service model for Northern Ireland: Evaluating the effectiveness of low-intensity CBT delivered in primary/community care settings (Policy Briefing, Knowledge Exchange Seminar Series, 8 March 2017). https://www.niassembly.gov.uk/globalassets/documents/raise/knowledge_exchange/briefing_papers/series6/kirby080317.pdf
18. Northern Ireland Assembly. Public Accounts Committee. (2024). Report on mental health services in Northern Ireland (Report No. NIA 39/22-27). Northern Ireland Assembly. https://www.niassembly.gov.uk/assembly-business/committees/2022-2027/public-accounts/inquiries/inquiry-into-mental-health-services-in-northern-irealnd/
19. National Institute for Health and Care Excellence. (2020). Generalised anxiety disorder and panic disorder in adults: Management (CG113). https://www.nice.org.uk/guidance/cg113
20. National Institute for Health and Care Excellence. (2022, June 29). Depression in adults: Treatment and Management. https://www.nice. org.uk/ guidance/ng222
21. Cross, S. P., & Hickie, I. (2017). Trans- diagnostic stepped care in mental health. *Public Health Research & Practice*, 27(2), 2721712. https://doi.org/ 10.17061/ phrp2721712
22. Clark, D. M. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: the IAPT experience. *International Review of Psychiatry*, 23(4), 318-327. https://doi.org/ 10.3109/ 09540261.2011.606803
23. Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16(9), 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x
24. Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, 166(10), 1092–1097. doi:10.1001/archinte. 166.10.1092
46. Davis, A., Smith, T., Talbot, J., Eldridge, C., & Betts, D. (2020). Predicting patient engagement in IAPT services: a statistical analysis of electronic health records. *Evidence-based mental health*, 23(1), 8–14. https://doi.org/10.1136/ebmental-2019-300133
47. National Health Service England. (2018, March 21). *The Improving Access to Psychological Therapies (IAPT) pathway for people with long-term physical health conditions and medically unexplained symptoms* https://www.england.nhs.uk/wp-content/uploads/2018/03/improving-access-to-psychological-therapies-long-term-conditions-pathway.pdf
48. McDevitt-Petrovic, O., & Kirby, K. (2020). Assessing the Effectiveness of Brief and Low Intensity Psychological Interventions for Medically Unexplained Symptoms and Health Anxiety: A Systematic Review of the Literature. *IntechOpen*. 10.5772/intechopen.93912
49. O'Mahen, H., Healy, S., Haycock, N., Igwe, S., Chilvers, R., & Butterworth, R. (2023). NHS Talking Therapies for anxiety and depression – Perinatal Positive Practice Guide (Revised 2023). CEDAR Centre for Research in Evidence-Based Practice. https://cedar.exeter.ac.uk/v8media/facultysites/hls/cedar/resources/Positive_Practice_Guide_FINAL.pdf
50. McDevitt-Petrovic, O., Shevlin, M., & Kirby, K. (2019). Modelling changes in anxiety and depression during low-intensity cognitive behavioural therapy: An application of growth mixture models. *British Journal of Clinical Psychology*, 59(2), 169–185. https://doi.org/ 10.1111/bjc.12237
51. McDevitt-Petrovic, O., Kirby, K., McBride, O., Shevlin, M., McAteer, D., Gorman, C., & Murphy, J. (2018). Preliminary Findings of a New Primary and Community Care Psychological Service in Northern Ireland: Low-Intensity Cognitive Behavioural Therapy for Common Mental Health Difficulties. *Behavioural and Cognitive Psychotherapy*, 46(6), 761–767. https://doi.org/10.1017/ s1352465818000322
52. McAnee, G., Gorman, C., Mulvenna, M., McDevitt-Petrovic, O. & Ennis, E. (2024). *Your Emotional Wellbeing Project Evaluation Report.* Action Mental Health.
53. Pelucio, L., Quagliato, L. A., & Nardi, A. E. (2024). Therapist-Guided Versus Self-Guided Cognitive-Behavioral Therapy. *The Primary Care Companion for CNS Disorders*, 26(2). https://doi.org/10.4088/pcc.23r03566
54. The British Psychological Society. (2022). *A psychological manifesto for the Northern Ireland Assembly.* https://cms.bps.org.uk/sites/default/files/2022-09/A%20psychological%20manifesto%20for%20the%20Northern%20Ireland%20Assembly.pdf
55. Royal College of Psychiatrists.(2022). *Mental health crisis in Northern Ireland cannot be overstated say psychiatrists*.

25. London School of Economics.(2006). *The Depression Report A New Deal for Depression and Anxiety Disorders.* https://eprints.lse.ac.uk/818/1/DEPRESSION_REPORT_LAYARD.pdf

26. Bank of England. (2025). *Inflation Calculator.* https://www.bankofengland.co.uk/monetary-policy/inflation/inflation-calculator

27. Department of Health.(2011). *Talking therapies: A four-year plan of action .* https://assets.publishing.service.gov.uk/media/5a7cdd6fed915d7c849adb5d/dh_123985.pdf

28. Wakefield, S., Kellett, S., Simmonds-Buckley, M., Stockton, D., Bradbury, A., & Delgadillo, J. (2021). Improving Access to Psychological Therapies (IAPT) in the United Kingdom: A systematic review and meta-analysis of 10-years of practice-based evidence. *British Journal of Clinical Psychology,* 60(1), 1-37. https://doi.org/ 10.1111/bjc.12259

29. NHS England . (2024). *NHS Talking Therapies, for anxiety and depression, Annual reports, 2023-24.* https://digital.nhs.uk/data-and-information/publications/statistical/nhs-talking-therapies-for-anxiety-and-depression-annual-reports/2023-24

30. Matsumoto, K., Hamatani, S., & Shimizu, E. (2021). Effectiveness of Videoconference-Delivered Cognitive Behavioral Therapy for Adults with Psychiatric Disorders: Systematic and Meta-Analytic Review. Journal of medical Internet research, 23(12), e31293. https://doi.org/10.2196/31293

31. Norwood, C., Moghaddam, N. G., Malins, S., & Sabin-Farrell, R. (2018). Working alliance and outcome effectiveness in videoconferencing psychotherapy: A systematic review and noninferiority meta-analysis. *Clinical psychology & Psychotherapy*, *25*(6), 797-808. https://doi.org/10.1002/cpp.2315

32. Mohr, D. C., Ho, J., Duffecy, J., Reifler, D., Sokol, L., Burns, M. N., Jin, L., & Siddique, J. (2012). Effect of telephone-administered vs face-to-face cognitive behavioral therapy on adherence to therapy and depression outcomes among primary care patients: a randomized trial. *JAMA*, 307(21), 2278–2285. https://doi.org/ 10.1001/jama.2012.5588.

33. Saxon, D., Broglia, E., Duncan, C., & Barkham, M. (2024). Variability in treatment effects in an English national dataset of psychological therapies: The relationships between severity, treatment duration, and therapy type. Journal of affective disorders, 362, 244–255. https://doi.org/10.1016/ j.jad.2024.06.115

34. Nguyen, J., McNulty, N., Grant, N., Martland, N., Dowling, D., King, S., … Dom, G. (2022). The effectiveness of remote therapy in two London IAPT services. *The Cognitive Behaviour Therapist*, 15, e23. doi:10.1017/S1754470X22000198

https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2025/01/31/mental-health-crisis-in-northern-ireland-cannot-be-overstated-say-psychiatrists

56. Department of Health. (2023, July 27). Northern Ireland mental health services workforce review 2022–2032. https://www.health-ni.gov.uk/publications/northern-ireland-mental-health-services-workforce-review-2022-2032

57. Royal College of Psychiatrists. (2011). *National Audit of Psychological Therapies for Anxiety and Depression: National report 2011.* Healthcare Quality Improvement Partnership (HQIP). https://www.hqip.org.uk/wp-content/uploads/2018/02/national-audit-of-psychological-therapies-reports-from-2011-2013.pdf https://www.hqip.org.uk/wp-content/ uploads/2018/02/national-audit-of-psychological-therapies-reports-from-2011-2013.pdf

58. Ulster University. (2020). *ICD-11 Complex Posttraumatic Stress Disorder: Introduction of a new psychological disorder and a tailored diagnostic assessment tool* (Impact Case Study). Ulster University. https://www.ulster.ac.uk/data/assets/pdf_file/0003/1149492/ICD-11-Complex-Posttraumatic-Stress-Disorder-Introduction-of-a-new-psychological-disorder-and-a-tailored-diagnostic-assessment-tool.pdf

59. Ulster University. (2021). *Changing Policy and Practice in Suicide Prevention* [Impact case study]. Ulster University. https://www.ulster.ac.uk/data/assets/pdf_file/0005/1149494/Changing-Policy-and-Practice-in-Suicide-Prevention.pdf

60. Ulster University. (2021). *Digital health technologies in mental health sciences: Using machine learning to enhance service design and delivery to people with mental health problems, people in suicidal crisis, and people living with dementia* [Impact case study]. Ulster University. https://www.ulster.ac.uk/ data/assets/pdf_file/0006/1150836/ICS3-Digital-health-technologies-in-mental-health-sciences-using-machine-learning-to-enhance-service-design-and-delivery-to-people-with-mental-health-problems,-people-in-suicidal-crisis-and-people-living-with.pdf