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# Using implementation intentions to prevent relapse after remission from psychological treatment for depression: The SMArT intervention

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## Abstract

**Objective:** To provide evidence of the effectiveness of a brief relapse prevention intervention using implementation intentions (Self-Management after Therapy, SMArT), following remission from depression and to identify effective relapse prevention strategies.

**Method:** The SMArT intervention was provided to 107 patients who were recovered after psychological therapy for depression. Relapse events were calculated as reliable and clinically significant increases in PHQ-scores. Sixteen patients receiving the intervention and eight practitioners providing it were interviewed. Framework Analysis identified seven themes which highlighted effective relapse prevention strategies and effective implementation of the SMArT intervention.

**Results:** Relapse rates at the final SMArT session (four months after the end of acute stage therapy) were 11%. Seven themes were identified that supported effective self-management: (1) Relationship with the practitioner—feeling supported; (2) Support networks; (3) Setting goals, implementing plans and routine; (4) Changing views of recovery; (5) The SMArT sessions—mode, content, timing, duration; (6) Suitability for the person; and (7) Suitability for the service.

**Conclusion:** The study provides some support for the effectiveness of the SMArT intervention, although a randomized controlled trial is required; and identifies important relapse prevention strategies.

**Keywords:** depression; self-management; relapse prevention; implementation intentions

**Clinical or methodological significance of this article:** This article presents evidence for the effectiveness and acceptability of a brief relapse intervention following remission from depression which incorporates implementation intentions. The intervention is brief and can be provided by practitioners with one-year postgraduate training, not trained and accredited psychotherapists; it, therefore, supports improved access and cost effectiveness. The study also identifies relapse prevention strategies that support long-term recovery from depression and could be incorporated into relapse prevention interventions.

## Introduction

Depression is recognized as the leading cause of disability worldwide and a public-health priority (Ferrari et al.,

2013). Many people experience it as either a long-term or re-occurring condition. The lifetime risk of relapse in

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patients has been reported as 40-60% after one episode of major depression, increasing with each episode to 60% following two episodes and up to 90% after three episodes (Kupfer, 1991; Moffitt et al., 2010; Solomon et al., 2000). Relapse rates are reduced with continuing use of antidepressants (Geddes et al., 2003) and psychotherapy (Steinert et al., 2014) but about half of people who improve after psychotherapeutic treatment suffer a relapse or recurrence within two years (Dobson et al., 2008; Hollon et al., 2005; Vittengl et al., 2007). A recent study in an Improving Access to Psychological Therapies (IAPT) service in England showed high relapse rates of 37% at four months and 50% at one year for patients who had recovered following low intensity Cognitive Behavioural Therapy (CBT) for anxiety and depression (Ali et al., 2017). The study found that 70% of the relapses which had been identified a year after the end of therapy took place in the first four months, which highlighted the need to provide relapse prevention interventions soon after the end of the acute phase treatment.

Recognition of the long term and relapsing nature of depression has led to a greater emphasis on long-term self-management approaches (Andrews, 2001) and this should include prevention strategies for patients in remission (Bockting et al., 2015). Some therapies include elements of relapse prevention, for example, Preventative Cognitive Therapy (Bockting et al., 2018), CBT with booster sessions (Gearing et al., 2013) and Continuation-phase Cognitive Therapy (Vittengl et al., 2007). There is also some evidence that mindfulness-based interventions (Goldberg et al., 2018) reduce relapse rates for depression (Piet & Hougaard, 2011) and that decoupling may be important in addition to managing residual symptoms (Segal et al., 2019), which may be achieved by both Mindfulness-based Cognitive Therapy and Cognitive Therapy (Farb et al., 2018).

In addition to improving the long-term benefits of psychotherapies, it is important to develop complementary, discrete and less costly psychological interventions and strategies which could be supported by a wider range of practitioners. This would improve access, especially as the development and evaluation of brief relapse prevention interventions has been limited (Rodgers et al., 2012). A key element of relapse prevention is to continue with effective strategies and behaviours that help a person stay well, so interventions which support sustained behaviour change should be considered.

A promising approach to health-related behaviour change is implementation intentions, which are designed to address the weak correspondence between what people intend to do and what they actually do (Gollwitzer & Sheeran, 2006; Sheeran, 2002). Translating an intention to a behaviour is

even more of a problem for people with low mood and avolition, so this approach may be effective in prompting people to carry out behaviours they may know would be helpful but find difficult to implement. Implementation intentions (IMPs) are “if, then” plans which prompt a response when a specified situation or cue is encountered (Sheeran & Webb, 2016). Situations can be external cues such as a time, event, or place, or internal cues such as feelings or cognitions. Responses can also be external (an overt behaviour), or internal (feelings or cognitions) (Prestwich et al., 2015).

Implementation intentions have been incorporated into a brief relapse prevention intervention called Self-Management after Therapy (SMArT), with encouraging indications of acceptability and effectiveness (Lucock et al., 2018). Specific elements of the design of the SMArT intervention were informed by research, for example, outcomes are improved if participants select their own goals and plans (Koestner et al., 2002); guidance and support increases the quality of the plans (Gallo et al., 2009) and improves outcomes (Luszczynska, 2006; Luszczynska et al., 2007); face-to-face “booster” sessions improve outcomes (Chapman & Armitage, 2010); and framing IMPS as plans that are personally relevant, rather than imposed, leads to better behavioural engagement (Adriaanse et al., 2009). There is also evidence that collaborative implementation intentions, involving two people planning to carry out the behaviour together, may be more effective than carrying out plans alone (e.g., Prestwich et al., 2012). Finally, a meta-analysis provides support for monitoring goal progress as an effective self-regulation strategy, which can include the use of diaries (Harkin et al., 2016). The SMArT intervention is therefore based on a theoretical framework, as recommended by the UK Medical Research Council (MRC) guidance on the development, evaluation and implementation of complex interventions (Craig et al., 2008), and designed in collaboration with patients and practitioners (Lucock et al., 2018) but more evidence is required to establish its impact on relapse prevention. The aims of this study were to investigate:

1. Relapse rates for patients receiving the SMArT intervention.
2. The perceived effectiveness and acceptability of the SMArT intervention.
3. Effective relapse prevention strategies which support longer term recovery.

## Method

### Design

This is a mixed methods exploratory study consisting of two phases: (1) a clinical trial of the SMArT

intervention, which included interviews with patients receiving the intervention and practitioners providing it; (2) Routine clinical outcomes in two services providing the SMaRT intervention and using the same outcome measures. Relapse rates were calculated at the end of the SMaRT intervention, which was four months after the end of acute stage therapy. The interviews were carried out with patients and practitioners to explore the perceived acceptability and effectiveness of the intervention and key relapse prevention strategies following depression. The study was conducted as part of the Northern Improving Access to Psychological Therapies (IAPT) Practice Research Network (PRN) (Lucock et al., 2016). This PRN supports collaborations between IAPT services, practitioners and academics to carry out practice-based research, using the same standardized outcome measures across all services.

### Setting

The outcome data was derived from three IAPT services which provide evidence-based psychological interventions for depression and anxiety disorders, based on national clinical guidelines (Clark, 2011). Brief CBT-based self-help interventions (known as low intensity interventions) are provided by Psychological Wellbeing Practitioners (PWPs). Formal psychotherapy (known as high intensity interventions) such as Cognitive Behavioural Therapy, Counselling for Depression or Interpersonal Psychotherapy are offered if the patient does not benefit from the brief intervention, or if it is apparent at initial assessment that a more intense and longer-term therapy is required. The study was given a favourable opinion by an NHS Research Ethics Committee (REC), and approved by the Health Research Authority (REC reference: 16/LO/0321; IRAS project ID 194000) and registered with the Research Registry at <http://www.researchregistry.com/>, reference number 2896.

In IAPT services, assessments are carried out based on agreed protocols described in the IAPT manual (National Collaborating Centre for Mental Health, 2019). The protocol includes: providing information about the service; a clear outline of the person's presenting problems, using International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) codes and the impact on their life; history of mental health problems; an exploration of any psychological processes maintaining problems; adverse life circumstances; a risk assessment; and identification of the person's therapy goals. Two IAPT services were involved in the phase one clinical trial, and they continued to provide outcome data in phase two, along with an additional service.

### Inclusion Criteria

Patients were offered the SMaRT intervention if: (1) Depression had been identified at assessment; (2) The patient had completed a psychological intervention for depression, including cognitive behavioural therapy, counselling for depression and/or a low intensity CBT self-help intervention; (3) The patient attained remission of both depression and anxiety symptoms at the end of therapy. Remission was based on a pre-post treatment change from above to below the clinical cut-off on the Patient Health Questionnaire (PHQ-9; Kroenke & Spitzer, 2002) and GAD-7 (Spitzer et al., 2006) which is the definition used to establish "recovery" rates in IAPT services and informs the decision to end therapy and discharge the patient.

### Measures

The PHQ-9 and GAD-7 were completed at every session. These are used in the clinical outcome monitoring system in all IAPT services in England.

1. The PHQ-9 is a nine-item screening measure for depression (Kroenke et al., 2001). Each item is scored on a 0–3 scale so the maximum score is 27. The clinical cut-off, indicating clinically significant depression symptoms, is 10 and above (Kroenke et al., 2001) and a statistically reliable change index of  $\geq 6$  points has been recommended (Richards & Borglin, 2011).
2. Although the focus of the intervention is on depression, the GAD-7 (Spitzer et al., 2006) was included to identify levels of and changes in anxiety scores. The seven items of the GAD-7 are also rated 0–3 with a clinical cut-off of 8 and above (Kroenke et al., 2007). A change of  $\geq 5$  points has been recommended as an indication of a reliable change in scores over time (Richards & Borglin, 2011).

### Procedure

Participants who met the inclusion criteria were given an information sheet describing the SMaRT intervention soon after their final therapy session, when it was established that they had met the remission criteria. If they expressed an interest in the intervention, they were contacted by a PWP by phone to discuss their participation, provide consent (if they were included in the phase 1 clinical trial) and set up the first SMaRT session. Two post-doctoral researchers (SK and WK) conducted semi-



structured telephone interviews with 16 patients who received the intervention, based on a topic guide which invited feedback on the delivery and content of using SMArT, how it supported the self-management of their mental health problems, and what helped them to stay well. In addition, telephone interviews with eight PWP who provided the SMArT intervention were carried out by a different researcher (RB), using a similar topic guide with further questions on the PWP's experience of providing the SMArT intervention, including how their training and skills equipped them for this role. All interviews were professionally recorded and transcribed.

### **The Smart Intervention**

The SMArT (Self-Management after Therapy) intervention is a brief relapse prevention intervention, to support people to stay well after psychological therapy for depression. It consists of one face-to-face session of up to an hour, in which a maximum of five IMPs (or "plans" as they tend to be called in the intervention) are agreed. Examples of IMPs are: "every evening (external cue) I will write down the positive things that have happened to me that day" (external response) or "If I feel low (internal cue) then I will talk to my partner about why this might be (external response)."

The IMPs build on the therapy and are informed by relapse prevention plans which may have been developed during the therapy. The IMPs prompt a person to continue to do the things that help them to stay well. This face-to-face session is provided soon after the end of the acute phase therapy and is followed by up to three 30-minute telephone sessions one month apart, to check on and support progress in relation to the plans. The intervention therefore spans four months after the end of the acute stage therapy. Diary sheets were used to monitor the extent to which patients were able to carry out the IMPs and any problems encountered, and patients were encouraged to share their IMPs with selected partners, friends or family members who could support them to carry out the plans.

It was previously established that the PWP training (a one-year part time Post Graduate Certificate including supervised practice) provided the necessary knowledge and competences in face-to-face and telephone based guided self-help (Lucock et al., 2018). In this study, an additional single workshop was provided which specifically focussed on the SMArT intervention and included demonstration videos and role plays.

### **Treatment Fidelity**

The IMPs were recorded and collated by the research team to determine the types of situation and responses, and to assess treatment fidelity by determining whether or not the situations/cues fitted the implementation intentions model. For an implementation intention to fit the model it must be sufficiently specific to prompt the response and in some cases the situations were too vague or general. For example, "every day, I will ... ." is too vague; but specifying morning, afternoon or evening is acceptable.

### **Quantitative Data Analysis**

In this study, a relapse event for depression was defined as an occasion when PHQ-9 scores were both above the clinical cut-off (<9 points) and an increase of  $\geq 6$  points (Richards & Borglin, 2011). This is consistent with the Jacobson and Truax (1991) criteria for reliable and clinically significant deterioration. Relapse rates were also calculated based on a reliable and clinically significant increase in scores on either the PHQ-9 or GAD-7.

### **Qualitative Data Analysis**

Analysis of interview data was conducted using the Framework method, which was developed to provide a structured, robust approach to analysis of qualitative health research, in order to inform service design and delivery (Kiernan & Hill, 2018; Spencer et al., 2014). Analysis of the patient interviews was led by author SK in consultation with the research team, an approach that enhanced analytical rigour through critical discussion, challenge and review (Richards & Morse, 2013). Systematic management of the analysis process was achieved through spreadsheets. They were used at every stage as simple grids containing chunks of labelled text (verbatim quotations; summaries; concepts; themes) that could be refined and revised whilst maintaining a straightforward link to the original source. Through systematic application of the five analysis stages (familiarization; identifying a thematic framework; indexing; charting; and mapping and interpretation), data were organized and categorized by type and content and ultimately brought into conceptual themes, using these charts. This method keeps the analysis grounded in the data and thus enhances its validity and credibility (Spencer et al., 2014). Analysis of the patient interviews identified five themes which were important for successful self-management after recovery. Analysis of the PWP interviews was led by author RB who coded

the PWP interviews in relation to the patient interview framework. This led to a refinement of the initial five themes and the identification of two additional themes relating to the suitability of the SMArT intervention for the patient and for the service.

## Results

### Relapse Rates and Attendance

One hundred and seven patients attended the first SMArT session, of whom 63% were female. Ages ranged from 19 to 83 years (mean = 45.7; SD = 15). Sixty-one (57%) had received low intensity CBT only, 35 (33%) a high intensity intervention only (mainly CBT), and 11 (10%) both high and low intensity interventions. Table I shows the mean scores and standard deviations at each stage on both the PHQ-9 and GAD-7.

Twelve of the 107 patients (11%) showed a relapse event, based on a reliable and clinically significant increase in PHQ-9 scores on at least one of the SMArT sessions.

For these 12 patients, three attended all four SMArT sessions and six attended three sessions. Two attended one session, one of whom returned to high intensity CBT therapy at that point (so did not continue with the SMArT intervention). Two of the 12 patients showed a relapse when they attended the first SMArT session (before they could benefit from the intervention), i.e.,; the one who returned to high intensity CBT and another who continued with the SMArT intervention (their scores reduced to sub threshold levels at subsequent sessions).

Relapse rates were also calculated based on a reliable and clinically significant increase in scores on either the PHQ-9 or GAD-7. Using this criterion, relapse events were found for 14 out of 107 (13%) of patients.

### Treatment Fidelity

The IMPS were available for 64 out of the 107 patients (60%), and analysed in terms of fidelity and types of situation/cue and response. The average number of IMPS per patient was 4.29 (range 1–7); 57% of situations or cues were external (43% internal) and 81% of responses were external (19% internal). Seventy-eight percent of situations or cues fitted with the acceptable specificity criteria for IMPs; all those that did not fit the criteria were not sufficiently specific.

### Qualitative Findings

Sixteen patients participated in individual interviews (n=6 from site A and n=10 from site B; 4 male and 12 female; age range 21–83 years). Of these, ten attended all four sessions, one attended three, one attended two sessions and four attended one session (the face-to-face session only). Only one of these patients (A3) experienced a relapse in depression, at their final SMArT session (this patient attended all the SMArT sessions).

Four themes which were important for relapse prevention and self-management were identified from the analysis of the patient interviews: (1) “Relationship with the practitioner—feeling supported”; (2) “Support networks”; (3) “Setting goals, implementing plans and routine”; (4) “Changing views of recovery.” A further theme was identified which related to the way in which the SMArT intervention was delivered: (5) “The SMArT sessions—mode, content, timing, duration”. These five themes fitted with the PWP interviews, which identified a further two themes relating to how suitable the SMArT intervention was for the patient and the service: (6) “Suitability for the person”; (7) “Suitability for the service.” The themes are described below with quotations which are labelled by site and participant number. For example, A1 is site A, patient participant number 1, PWPB2 is site B, PWP participant 2.

Table I. Mean PHQ9 and GAD7 scores at each session.

	PHQ9 pre therapy	PHQ9 post therapy	PHQ9 at SMArT session 1 (face-to-face)	PHQ9 at SMArT session 2 (telephone)	PHQ9 at SMArT session 3 (telephone)	PHQ9 at SMArT session 4 (telephone)
PHQ9 Mean (SD)	16.8 (4.1)	3.7 (2.6)	4.7 (3.3)	4.9 (4.1)	4.7 (3.6)	3.7 (3.4)
N	107	107	107	93	78	59
GAD7 Mean (SD)	13.0 (4.1)	3.1 (2.6)	3.9 (3.3)	3.9(3.8)	3.7 (3.3)	3.6 (3.3)
N	107	107	107	93	78	58

Note: PHQ9: patient health questionnaire; GAD7: generalized anxiety disorder assessment; SMArT: self-management after therapy intervention; SD: standard deviation; N: sample size.

**Theme 1: Relationship with the Practitioner —Feeling Supported.** This theme relates to support from the PWP which also provided a bridge between the end of therapy and being discharged from the service. Most patients described common therapeutic factors identified in psychotherapy research, such as feeling listened to, accepted and not judged:

A1: I really, really do think it's an absolutely amazing thing, that there's people out there that don't judge and that just sit and listen to you, ... about how you feel and they don't judge you, they just accept you for who you are and what you are.

Some patients used powerful language to convey how the phone calls provided a safety net and the feeling that they had not been abandoned:

A6: It wasn't like "get lost" at the end of treatment -it's like jumping off a diving board, into the water, if you've got your arm bands on, you'll be alright, if you didn't, and you can't swim- but it's just giving you a little bit of... I don't know what it is, but it gives you confidence, to know you're not on your own ... a lifejacket: Someone to remind you that you can cope.

Some patients also clearly stated how this support helped them to stay well and prevent a relapse.

A5: I've always crashed again and for a time, I was expecting to crash again, you know, but I was doing very well and I think the follow-up phone calls and discussions helped me to, you know, it wasn't just like right, that's it, you're feeling better, end of ... it's kind of weaning off ...

PWPs also reflected on the value of the support and back up they provided to patients:

PWPB2: I think it was that, not just that sudden end therapy. I think it was that kind of checking in, part of it, and that checking in, not being too intrusive, or having too much on, that checking in, just making sure that they're kind of doing things that they were already doing that was helping.

PWPs also highlighted the importance of collaboration to identify IMPs:

PWPA5: I just think because you can obviously build up a bit of a, start building up your therapeutic relationship with the person and just obviously to come up with the IMPs. It was just good to be there together and obviously they write them down, but work through it together.

## **Theme 2: Support Networks**

Most patients shared their plans with one or more other person and parents, grandparents, spouses and trusted friends were among those mentioned.

A1: I had my partner and I had one of my friends, who wasn't necessarily going through a very good time, but she agreed, but we sort of talked about it and she agreed to be my sounding port, my sounding board, if I wasn't having a good day [I: right], so I could ring her up and we'd sit and we'd chat ...

This was supported by the PWPs:

PWP A3: But I think that helped the fact that her IMPS were involved with people, gave her more encouragement to carry them out anyway, because she had other people to do them with.

PWP B2: I think the clients I had were quite open with their partners and their friends and family about what they were doing with the project.

Several patients said that seeking support from others was new to them. B8 said she had not previously done this because she did not want to cause distress:

B8: (I involved) my husband and my auntie and my uncle and my best friend ... it did [help] because I always found it difficult to speak to people and tell them about how I was feeling. I didn't want to upset them as well.

A barrier to involving others was concerns about being judged in a negative way:

A6: I spoke to a couple of friends, with different results. Some ... seem to think it's almost something to be ashamed of, to be, well losing your mind and things like that, they're very "pull yourself together!". I can see now they don't understand, it's not that they're being horrid.

## **Theme 3: Setting goals, implementing plans and routine.**

Patients described how the follow up calls helped them to consolidate their skills in setting, implementing and revising goals and plans to support their recovery, and the importance of routine. For example, A3 was enthusiastic about setting plans (implementation intentions/IMPS) and thought that this helped them to stay well:



A3: I would not have made all the gains without the follow up. Setting plans was a really important way to stay well using the techniques I was taught. Plans wash away all the [mental and emotional] rubbish. You can trust the rules.

B2 described the importance of routine and planning the day ahead:

B2: I'm focusing on what I'm going to be doing the next day more and I'm sticking to it, like I've got a routine now, where I tended not to have ... I'm obviously not as lethargic and tired. I've made myself, you know, get up and go sort of thing ... Whereas now I've got more of a routine. I'm getting up, I'm going and watering my garden, I'm doing this, I'm doing that, you know and I plan my day more.

It was also clear that the plans (IMPs) often built on the work of the acute stage therapy:

A5: I'd already set plans and coping mechanisms and things like that, when I was seeing [the therapist] and it was reaffirming basically those plans and which ones were I using, which ones were most helpful ...

Several said that having things written down was helpful to remember the IMPS/plans and refer back to them when needed:

B3: Because I'd wrote it down and I had to sit and think about it, I think it just, it sticks with you doesn't it.

B5: Having it written down on paper, something to refer back to and obviously discuss how I was getting on with it in each session was useful.

#### Theme 4: Changing Views of Recovery

This theme relates to changes in views about what recovery means, and what is required to support it. It includes patients being more aware of their needs, less judgmental of themselves if they did not achieve their planned goals, more flexible about revising and re-setting plans, seeking the support of others, and recognizing recovery and seeing it as a longer-term process with its ups and downs, with inevitable setbacks. These quotes from PWPs reflect this:

PWPA4: ... they're still on a bit of a journey in terms of kind of continuing to apply what they've learnt and that kind of thing.

PWPA5: ... just to help them, you know, help remind them that okay you've finished therapy now, but it's important that you're continuing to

do x, y, z, to then help to, you know, maintain that improved mood.

A1 was one of several patients who had learned that "you need a support network" to keep well. B5 described how, by working with the PWP, their perspective changed in that they developed insights into why things were going wrong and used that to work out appropriate goals.

B5: We sort of looked at how my values had become sort of out of line and so setting goals into how we were going to bring those back into line ... from that point on it became quite easy.

Several patients said new ways of thinking, that stayed in their minds, helped them to remember helpful techniques and strategies to enable them to stay well. For example:

A1: Set a target and do it, don't sort of, don't think about it.

B1: ... if your mind has sort of gone blank ... you think okay, I know what I've done in the past, I've got the techniques, I know how to do stuff in the future ... There was one thing that the lady said, which, and it's took me a long, long time to get that in my head in terms of, if something doesn't work that day, or you feel really down that day, don't worry, try again tomorrow; and that's, that's something that its possibly one of the biggest things that made a difference, not chastising myself.

Some patients also talked about how the importance of routine and planning the day ahead stayed with them as a helpful strategy, for example, the earlier quote from B2.

#### Theme 5: Smart Sessions- Mode, Content, Timing, Duration

A large number of comments were made by patients and PWPs about the suitability of the SMARt sessions, including their mode of delivery (face-to-face and telephone), length and frequency. Varying views were expressed, with some preferring telephone contact, others face-to-face sessions. For example, A5, who lived in a rural area, was pleased to access support over the phone without having to attend appointments.

A5: I had quite a good rapport with the telephone, it wasn't possible for us to meet. I live out in the middle of nowhere and you know, it wasn't really possible to meet. So we had them by telephone and it was absolutely fine.

Most patients reported that the phone calls helped them to consolidate and apply implementation intention strategies to aid their recovery, were helpful prompts to look at their plans, monitored their mental health, and provided information, advice, encouragement, regular contact and reassurance about how the strategies worked. Concerns expressed included that telephone calls may be a “cost-cutting exercise,” that it was inferior to face-to-face contact, and that the phone calls were occasionally disorganized. In some cases, patients felt they had moved on, so they were not necessary anymore, suggesting they did not feel the need for continued support. Although most of the feedback was positive, the structure of the intervention did not suit everyone:

A2: It’s not a one size fits all ... the original CBT was quite helpful to me, that’s because I think the therapist understood, you know, my kind of background and was kind of low key and listened to me more. Now I found the face-to-face stuff far, far too prescriptive ... therapist was trying to basically tell me how to organise my life a little bit, at certain times and that was a complete turn-off to me.

The PWPs also stressed the importance of individual preference in the way the sessions were provided:

PWPA1 I think some people like the phone calls because they’re not too invasive. Whereas some people like to come and see you face-to-face ...

### **Theme 6: Suitability for the Person**

This theme reflects the finding that although the intervention was liked and perceived as beneficial by most patients, a few found it unhelpful and/or disengaged from the intervention:

PWPA5: ... two or three people seemed to disengage, so I just think that perhaps, perhaps if anything it suited some people but not everybody.

The earlier quote from A2 who said “It’s not a one size fits all ...” is an example of a poor match between the intervention and the patient who found the approach “far too prescriptive”. In some cases, disengagement was seen as being due to practical issues:

PWPA5: So one person that disengaged, like she changed jobs or something and was having a nightmare at work.

In other cases, disengagement seemed to be a more positive sign that the patient was continuing to

engage with the IMPS but didn’t feel they needed further sessions:

PWPA6: I had someone who cancelled the first face-to-face phone call, just saying that she feels like she, she’s using, she found the initial session really helpful, but she just feels like she doesn’t need the face-to-face phone calls. She’s kind of just happy to carry on herself. But still working on the IMPs ... she just felt like she didn’t need the face-to-face.

### **Theme 7: Suitability for the Service**

This theme refers to the extent to which the SMARt intervention fitted with the role of the PWPs, service priorities and treatment pathways. All the PWPs felt the intervention fitted in very well with their role and that their core training equipped them to deliver the intervention effectively. It also extended their competencies and their confidence increased as they provided more sessions, and it provided more balance for their caseloads:

PWP A4: I found it really positive actually, but it’s like something that I maybe don’t do that often, so it does take a bit more, if you don’t do something as regular, it takes a bit more time.

PWP B1: I found it was nice from a clinician point of view, nice to work with people who were well ...

Challenges included getting other staff to be aware of the intervention, PWP staff turnover and fitting the work in with other service demands.

PWP B1: I think how it flowed, this is probably more of a service thing than the actual intervention, but getting it ingrained in our service was really, really difficult, getting people on board, especially the clinicians, quite disjointed to get it as part of us kind of general routine.

PWPs also said the intervention was suitable as a follow up relapse intervention in the service’s treatment pathway:

PWP B2: ... after therapy, people kind of feel like they’re left on their own and especially with depression, because people can relapse so easily, well so commonly, I thought it was really good to have something they could focus on to kind of really, really, really characterise what helps them stay well and just having that wrote down in front of them and that continuation of the relapse prevention plan seemed to really work well.

## Discussion

This study provides evidence of the perceived effectiveness of the SMaRT intervention from patient and practitioner perspectives and identifies effective relapse prevention strategies for depression. The relapse rates were relatively low, 11% in PHQ-9 scores and 14% based on either PHQ-9 or GAD-7 scores by the final session (within four months after discharge from acute stage treatment), which compares favourably with the relapse rate of 37% at four months in the Ali et al. (2017) study. Although the Ali et al. study used the same outcome measures in a similar IAPT service, there were differences between the two studies; for example, the Ali et al. study followed up patients receiving low intensity CBT only, whilst in the current study 57% had received low intensity CBT and 43% high intensity CBT, which one would expect to result in better long-term outcomes. In fact, of those who showed a relapse event in the current study, five had received high intensity CBT and seven low intensity CBT so there was no clear relationship, although the numbers are low. Wojnarowski et al. (2019) point out the difficulties comparing relapse and remission rates for depression between studies due to different definitions and time periods.

Threats to internal validity of the current study include possible selection biases, so that patients opting for the intervention may have been less likely to relapse, and a randomized controlled trial would be required to establish the efficacy of the SMaRT intervention. It is also possible that those who deteriorated disengaged from the intervention. However, a strength of the study is that we did interview patients who disengaged and some reported ending sessions because they were doing well and no longer needed support as well as practical reasons for disengagement, such as work commitments (rather than a deterioration).

The qualitative analysis identified three key relapse prevention strategies which were supported by the relationship with the PWP—support networks; the importance of goals, plans and routine; changing views of recovery. The relationship with the PWP was established despite just one face-to-face session and patients reported familiar features in an effective therapeutic relationship, such as feeling accepted and not judged. The importance of the therapeutic relationship is consistent with research across different psychotherapies and mental health problems (Flückiger et al., 2018) and a recent review suggests no significant interactional differences between telephone and face-to-face psychological therapy (Irvine et al., 2020). In the SMaRT intervention the relationship was clearly appreciated as a bridge

between the acute stage therapy and discharge and the analogy of a life jacket was very striking.

The importance of implementing plans and establishing routines suggested implementation intentions (as well as general support) were an important part of the SMaRT intervention and seemed to be more effective if they were planned and carried out with support from partners, friends, and family. Social support is well established as an important protective factor against depression (Garipey et al., 2016) and it is a strength of the SMaRT intervention that sharing plans with others is built into the intervention, consistent with collaborative implementation intentions (Prestwich et al., 2012). Changing views of recovery included seeing it as a journey with ups and downs and setbacks, to accept this without self-blame, routinely incorporating good habits and actively seeking support from others. It is possible that discharging patients when they meet an explicit criterion for “recovery” or “remission” may reinforce a binary, black or white view that they are either well or not well, which may lead to a sense of being “back to square one” if they experience setbacks. The interviews supported an alternative view that recovery and self-management should be seen as an ongoing journey, accepting continued challenges as inevitable and setbacks as likely, and that this view supports recovery. This is particularly true for people living in ongoing adverse and challenging life circumstances who may have to live with ongoing challenges to their mental health.

The first four themes (“Relationship with the practitioner—feeling supported”; “Support networks”; “Setting goals, implementing plans and routine”; “Changing views of recovery”) are important relapse prevention strategies in general, whilst the last three themes (“The SMaRT sessions—mode, content, timing, duration”; “Suitability for the person”; “Suitability for the service”) were more specific to the SMaRT intervention. There were differing views from patients on the pros and cons of telephone and face-to-face sessions, which suggests some degree of flexibility should be applied. Having said that, an initial face-to-face session to explain the intervention, identify the IMPs and establish the therapeutic relationship seemed to be important. The requirement for specificity of the IMPs did not suit all patients, suggesting some may not like the structured, more directive nature of the SMaRT intervention, and evidence that patients with higher levels of resistance respond best to nondirective treatments (Beutler et al., 2011) may be relevant. The final theme of suitability for the service is important to local implementation because it relates to the extent to which the intervention fits with service priorities and takes account of local context. Key

performance indicators for IAPT services include recovery rates but the SMaRT intervention does not increase recovery rates (because the patients have already recovered) so may not be seen as a priority. Hopefully, relapse prevention interventions will be given more priority in the future if services routinely follow up patients after discharge and there is more awareness of relapse rates and referrals.

This study describes just one way in which implementation intentions can be integrated into the treatment pathway to prevent relapse and support self-management. There are of course other ways, such as integrating it into the acute phase treatment, although the study suggests that the support provided by the follow up sessions may be important. Although the focus of the intervention was on depression due to the strong evidence for relapse, some of the IMPS related to managing anxiety-related problems such as avoidance of anxiety provoking situations. There was no attempt to separate out depression related IMPS from anxiety related ones, the focus was on what helps the person to stay well and continue with their recovery.

This study has a number of strengths, such as the fact that it is a brief intervention based on an established and empirically supported method, using implementation intentions, and the mixed methods identified relapse rates, feedback on the perceived effectiveness of the SMaRT intervention and information on relapse prevention strategies. However, it is important to interpret the findings in the light of several limitations. Firstly, it has already been acknowledged that it was an exploratory and uncontrolled study, with threats to internal validity such as potential biases, so no firm conclusions can be made regarding the efficacy and the most robust methodology would be a randomized controlled trial. Secondly, only patient-reported measures were used, rather than diagnostic criteria which are regarded as more valid and associated with lower relapse rates (e.g., Levy et al., 2021). Although the PHQ-9 and GAD-7 have good psychometric properties we did not make formal diagnoses of depression either at the start of the acute stage treatment, nor when determining relapse. Thirdly, we did not record the use of antidepressants so it is not known to what extent the patients were taking antidepressants during the acute phase treatment, nor during the follow up phase when they received the SMaRT intervention. Fourthly, although we report an indication of treatment fidelity in terms of the IMPs, there was no other measure of fidelity and this would be required in an RCT. Finally, we do not have systematic data on the length of time between the end of acute

stage therapy and the first SMaRT session so we have been unable to report this. Feedback from PWPs suggest it varies from one week to a month and that the complete SMaRT intervention took place within four months after the end of acute stage therapy.

Despite these limitations, the low relapse rates and feedback from patients and PWPs is encouraging and suggests the SMaRT intervention warrants further service provision and evaluation with randomized controlled trials. We see SMaRT as complementary to existing psychological therapies for depression, not an alternative. It is a brief intervention, which fits with the role of PWPs who have received relatively brief training, and is therefore promising from a cost effectiveness perspective. It also suggests implementation intentions are an encouraging way of supporting self-management and reducing the likelihood of relapse in depression. This study also contributes to understanding effective relapse prevention strategies which are important in self-management and supporting an ongoing recovery process which takes account of the ongoing vulnerabilities and adverse life circumstances which affect many people.

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