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Evaluation of a Transdiagnostic Group Intervention in a Primary Care Mental Health Service: A Pilot Study

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Abstract

Adults with complex mental health difficulties (including those diagnosed with a personality disorder) are often seen in primary care settings with limited access to appropriate psychological therapies. A seven-session group treatment programme, the Coping Skills Workshop (CSW), was developed that combined both Cognitive Behavioural Therapy (CBT) and Dialectical Behavioural Therapy (DBT). The study evaluated the efficacy of a modified version of the CSW. 52 patients (aged 18 years and above) who were under the care of a Primary Care Mental Health Service (PCMHS) in London were referred into the CSW. 26 were randomly allocated to the group treatment programme and 26 to a wait-list control condition (Treatment as Usual; TAU). All participants completed four mental health outcome measures that assessed levels of depression (PHQ-9), anxiety (GAD-7), daily functioning (WS&AS) and general wellbeing (SWEMWBS), at pre- (first session) and post-intervention (end of seventh session). Participants in the wait-list control group completed the measures at similar time intervals. Participants in the treatment condition showed a significant clinical reduction in symptom severity in both PHQ-9 (20%) and GAD-7 (45%) scores alongside an improvement in SWEMWBS scores (17%). In contrast, the TAU group showed a significant deterioration in mental health symptoms at the post-score stage. The findings suggests that the brief transdiagnostic CSW intervention is efficacious and appropriate for individuals with complex mental health difficulties. Further investigation may include populations from different backgrounds and comorbidities.
Key words: coping skills, group transdiagnostic, cognitive behavioural therapy, dialectical behavioural therapy, primary care mental health service.

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Novelty and Significance

What is already known about the topic?

- Research provides robust advantages of using transdiagnostic group psychological interventions informed by DBT and CBT in the NHS Primary Care Mental Health Services.
- Series of outcome measures questionnaires can be useful to monitor the group workshop and review service-users' scores of moving towards recovery.

What this paper adds?

- The implementation of the brief, Coping Skills Workshop has been shown to improve service-users' symptoms of depression and anxiety and general wellbeing.
- The result of this study allows a strengthened awareness of a cost-effective way in providing treatment for mental health.

Around 17.6% of the adult population have common mental health problems of anxiety and/or depression (McManus, Meltzer, Brugha, Bebbington, & Jenkins, 2009). Ninety percent of service users with mental health difficulties are seen in primary care (Fletcher *et alia*, 2009; Shepherd, Cooper, & Brown, 1996). In England, most focus has been placed on providing access to treatment for these common mental health problems (i.e. anxiety and depression).

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However, when defining the term 'mental health', we need to take other complex mental health difficulties into consideration. These include conditions such as bipolar disorder, personality disorder, etc. Typically, they account for around thirty to fifty percent of people under primary care services (Naylor, 2020).

Initially, the responsibility for dealing with these service-users falls with GPs, who often feel undertrained or insufficiently experienced to manage these complex mental health issues (Naylor, 2020). Primary Care Mental Health Services act as a way to support GPs to deliver optimal holistic mental health care for these service-users.

The Primary Care Mental Health Service (PCMHS) in West London was developed in 2013 to support service-users in local boroughs with moderate to severe mental health difficulties. The multidisciplinary team (MDT) provides clinics, typically within GP surgeries improves ease of access to treatment (WONCA, 2008). As a result of this, GPs and the PCMHS can form close working relationships, helping to deliver good collaborative care and help service-users to remain well.

Service users seen by the PCMHS are also often unable to access treatment from the Improved Access to Psychological Therapy (IAPT) service as their diagnosis and treatment is too complex (Clark, 2011; Department of Health, 2011; Naylor, 2020). Therefore, a referral is made to PCMHS, as the service supports service-users with a broad range of diagnoses, including, Emotional Unstable Personality Disorder (EUPD) and Bipolar affective disorder.

In terms of available treatments, although antidepressant medications are a common first treatment for mental illnesses, their use is limited by side-effects, poor patient adherence and high relapse risk when medication use is discontinued (Amick *et alia*, 2015). Empirical research has shown that Cognitive Behavioural Therapy (CBT) is as effective as antidepressants (Amick *et alia*, 2015) and has a strong effect on common mental health problems such as depression and anxiety (Cape *et alia*, 2010).

However, evidence of CBT alone for complex mental health difficulties such as Schizophrenia, Bipolar Disorder (BD), Manic episodes and Emotionally Unstable Personality Disorder (EUPD) suggests this approach is limited in terms of its effectiveness (Hofmann *et alia*, 2012). Typically, treatment often needs CBT plus medication treatment -this is especially true for service-users with EUPD (Chiang *et alia*, 2017).

Treatments such as Dialectical Behaviour Therapy (DBT) have been developed and have been found to be effective for treating disorders such as EUPD (Linehan, 1993a, b; Tomlinson, 2018). Studies have shown that service-users who are treated with DBT therapy demonstrate a significant improvement in negative affect and emotional dysregulation along with improvements in wellbeing and control over their environment (Eisner *et alia*, 2017). Other studies have also reported reductions in aggressive behaviours and lower rates of depressive symptoms (Koons *et alia*, 2001; Meygoni & Ahadi, 2012), fewer EUPD symptoms (Uliaszek, Hamdullahpur, Chugani, & Rashid, 2018), reduced hopelessness, and self-harm (Stepp *et alia*, 2008) by the end of treatment. Nevertheless, to be effective, standard DBT therapy in a community public mental health setting, requires a long treatment duration of around 12 months (Flynn *et alia*, 2020a, b).

There are an increasing number of research studies which have considered 'transdiagnostic' psychological treatments that combine aspects of different treatment models to treat a broader range of mental health disorders. Erickson, Janeck, and Tallman (2007) found that Transdiagnostic Cognitive Behaviour Therapy (TD-CBT) in a group format was more effective (with a moderate effect size) compared to a waitlist condition or 'Treatment As Usual' (TAU) condition in reducing symptoms of anxiety.

In a systematic meta-analysis review by Newby, McKinnon, Kuyken, Gilbody, and Dalgleish (2015), transdiagnostic treatments led to significant reductions in both anxiety and depression, along with moderate improvements in quality of life.

These studies show that it is possible to achieve success when treating several disorders simultaneously in a group situation. In addition, group interventions enhance participants' social participation and promote hope through observing the progress with other people (Newbold *et alia*, 2013; Proudfoot, Corr, Guest, & Dunn, 2009) which is a further benefit to be gained from this approach.

Considering the current options available, a brief intervention informed by DBT and CBT within the remit/ operational policy of the PCMHS, would be of considerable benefit. The general aim here is to evaluate the efficacy of a transdiagnostic group treatment programme in PCMHS, incorporating both CBT and DBT therapy -the 'Coping Skills Workshop' (CSW). The CSW was developed by Marinho and Rashed (2015) to treat people with complex mental health difficulties. This early, brief, evidence-based intervention teaches participants effective CBT skills (such as problem solving, goal setting and thought challenging) as well as emotion regulation, interpersonal skills, and mindfulness awareness (from DBT). This aims to help participants cope and decrease their mental illness symptoms (Rowan & Runyan, 2005; Melnyk *et alia*, 2006). The CSW aims to improve each participant's mental health and social and occupational life.

Currently, there is limited evidence on the effectiveness of brief transdiagnostic group treatment programmes offered in primary care settings for service-users with mild to severe mental health difficulties. Specifically, this research will examine whether a modified version of the CSW is an effective intervention to improve service-users' mental health as measured by a series of clinical outcome measures. The 'treatment group' will be compared to participants in a waitlist control. Measures that have already been developed and established will be used to provide a valid pre- and post-treatment comparison. These include: Generalised Anxiety Disorder 7, (GAD-7 by Spitzer, Kroenke, Williams, & Löwe, 2006); Patient Health Questionnaire 9, (PHQ-9 by Kroenke, Spitzer, & Williams, 2001); Working Social and Adjustment scale, (WS&AS by Mundt, Marks, Shear, & Greist, 2002) and the Short Warwick-Edinburgh Mental Well-being Scale, (SWEMWBS by Tennant *et alia*, 2007).

It is predicted that participants in the treatment group (i.e., participants receiving the CSW group-intervention) will show significant clinical improvement and higher wellbeing scores by the end of the treatment compared to the wait-list control group.

Method

Participants

All individual participant referrals were reviewed and screened for eligibility (see Table 1) within London Borough of Ealing and Hounslow GP practices. Participants had to be aged at least 18 years old to participate in the intervention. Any referrals that came from other sources, such as secondary care services, were also triaged before being accepted onto the Coping Skills Programme. Only 52 (*M age*= 42, *SD*= 15.46) randomly selected participants between November 2018 and July 2019 were included in this evaluation. There were 32 females (62%) and 20 males. Thirty-seven (71.2%) of those were White (British and Scottish), seven (13.5%) were British Indian, three (5.8%) were British Pakistani and three Spanish (5.8%) and two were British African (3.8%).

Table 1. Inclusion and Exclusion Criteria.

Criteria	Included	Excluded
Participants	Participants need to be registered with a GP in the Boroughs of Hounslow and Ealing.	Participants who have complex needs (e.g. prominent suicide ideation).
Focus	Diagnosed with depression, anxiety, emotionally-unstable personality disorder (EUPD), bipolar affective disorder, psychosis (e.g. paranoid schizophrenia).	Participants who are diagnosed with dementia, eating disorders. Treated by clozapine medication.
Intervention	Can wait up to 28 days to have contact with the PCMHS.	Participants who might be too anxious when participating in group therapy (to avoid placing more distress on such participants). Participants who are unable to use the materials due to impaired concentration/motivation. Participants who do not understand the English language sufficiently to be able to complete the study measures and engage in the group.

Design

A mixed design was used with a between-subjects factor, where participants were allocated to either treatment or a waitlist control condition. Participants in both conditions were asked to complete four self-reported, outcome measures scores (dependent variables) on depression (PHQ-9), anxiety (GAD-7), daily functioning (WS&AS) and positive wellbeing (SWEMWBS) at the first session/week and at the seventh session/week. This allowed comparison of scores over time: pre-to-post intervention (within-subjects factor). The CSW took place face-to-face in an NHS clinic adjacent to a GP clinic.

Instruments and Materials

Ethical approval was reviewed and approved by the NHS West London Trust, Primary Care Mental Health Service as an audit service evaluation report. Around 30-35 participants (due to the maximum room capacity) were given an invitation letter by the PCMHS Trust for the upcoming Coping Skills Workshop (CSW) including dates and timings. The workshops consisted of seven separate sessions which were outlined in the workbook handouts. These workbooks, which were given to the participants at the start of the workshop, also contained some space for 'putting into practice' (homework) tasks. These handbooks included: Managing Unhelpful Thoughts (session 1); Managing Unhelpful Behaviours (session 2); Managing Stress and Worry (session 3); Sleep Management (session 4); Managing Difficult Emotions (session 5); Managing Interpersonal Difficulties (session 6) and Maintaining Wellbeing (session 7). The psychologist taught the sessions using a flipchart and pens. Copies of seven workbook handouts are available from the lead author on request. There was a 10-15 minute break in the middle of the workshop, where participants were provided tea/coffee and biscuits. Before starting each session, participants were asked to complete the four outcome measures scores which are outlined below. For the waitlist control condition, the four outcome measure scores were obtained through contacting participants over the telephone.

Patient Health Questionnaire -9 (PHQ-9; Kroenke *et alia*, 2001). The PHQ-9 is a self-report administered questionnaire for measuring and monitoring symptoms of depression. The scale contains 9 items corresponding to the nine diagnostic criteria for DSM-IV. The patient answers each statement by scoring on a scale of 0 ('not at all') to 3 ('almost everyday'), how troublesome each problem has been during the past two weeks. The

total scores that range from 0-4 indicate minimal depression; 5-9, mild depression; 10-14, moderate depression; 15-19, moderately severe depression; and a score between 20-27 indicating severe depression. The PHQ-9 has shown excellent internal reliability (Cronbach' α= 0.86), with good construct and convergent validity (Kroenke *et alia*, 2001).

Generalised Anxiety Disorder -7 (GAD-7; Spitzer, Kroenke, Williams, & Löwe, 2006). This self-administered scale consists of 7 items, that assess a generic measure of anxiety severity. Participants were asked to rate, 0-3 (ratings similar to PHQ-9), about how much over the last two weeks they have been bothered by each statement. The total score results from 0-21, with cut-off scores of 5, 10, 15 representing mild, moderate and severe levels of anxiety. The GAD-7 has been shown to have excellent internal consistency (Cronbach' α= 0.92) and good test-retest reliability (r= 0.83) with other anxiety scales (Kroenke *et alia*, 2010).

Working Social & Adjustment Scale (WS&AS; Mundt *et alia*, 2002). The five-point WS&AS assesses the impact of an individual's mental health difficulties (daily impairment functioning) on their work, home management, social leisure activities, private leisure activities and relationships. When a participant experiences extreme dysfunction (a score of 8 or higher) on at least three or four domains, they are seen by specialised mental health care services.

Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS; Stewart-Brown *et alia*, 2009). The SWEMWBS scale contains seven items representing four aspects of psychological and eudaemonic (e.g., self-realisation) wellbeing, whilst the last three items cover hedonic (e.g., life satisfaction) wellbeing (Ryan & Deci, 2001). The seven statements are positively worded and are rated on a 5-point Likert-type response scale from 'none of the time' to 'all of the time'. Scores range from 7 to 35. A high score indicates higher positive mental wellbeing over their previous two weeks.

Procedure

The workshops were held at an NHS clinic on Wednesday afternoons. The room and chairs were set up in a circular group layout, as this was found to encourage most effective interaction compared to a rows/classroom arrangement. The flipchart, cups, and biscuits, along with all the handout booklets and the outcome measures scale materials, were all arranged before the session started. Once the room was ready for the group, participants were asked to complete the four outcome measures scores. Thus, the selection process/sample was organized using the 'experience' or 'event-sampling' method, where clients were asked to report and comment on their daily life on multiple occasions over time (Verhagen, Hasmi, Drukker, Van Os, & Delespaul, 2016). Participants were also notified that their scores were confidential and would be anonymized throughout.

All four outcomes' measures scores and the client feedback were recorded in SystmOne (clinical computer programme system). Participants raw completed paper forms were destroyed. The data for the first session and the final seventh session was recorded into a spreadsheet for research purposes (i.e., the current study). This facilitated a comparison to see if the participants, overall, had improved and benefitted from the programme.

For the waitlist control condition, the participants were selected at random from the Trusts' waitlist spreadsheet and only 26 participants were contacted through an office-based telephone. Participants who could not answer the outcome measures, or said that they no longer needed CSW intervention, meant that the next participant was contacted.

Wait-list participants were told that they would be invited into the next cohort. Participants were contacted again at the seventh week to go over the same outcome measures scores. All instructions were standardized and used throughout ensuring consistency and clarity for all 26 participants.

RESULTS

A 2x2 mixed MANOVA was conducted with one between-subjects factor with two levels (condition; treatment vs. waitlist control) and one within-subjects factor with two levels (pre-intervention score vs. post-intervention score). The dependent variables were the four mental health outcome measures scores (PHQ-9, for measuring depression; GAD-7, for measuring anxiety; WS&AS, for measuring participants' daily functioning and SWEMBWS for measuring general wellbeing).

A significant multivariate interaction effect was observed between condition (treatment and waitlist) and intervention time (pre and post), Pillai's V= .48, $F(4,47)$= 10.95, p <.001, $\eta 2p$= .48, with a moderate effect size. There was also a significant multivariate main effect of time (within-subjects) on the four outcome measures scales, Pillai's V= 0.23, $F(4,47)$= 3.45, p= .02, $\eta 2p$= .23, with a moderate effect size. However, there was a non-significant multivariate main effect between the two conditions (between-subjects), Pillai's V= .16, $F(4,47)$= 2.22, p= .08, $\eta 2p$= .16, with a moderate effect size in magnitude.

The significant interaction effect justified 2x2 mixed factorial ANOVAs on the four dependent variables separately –see Table 2.

Table 2. Mean's (SD's) for all four outcome measures scales as a function of client's treatment intervention and control waitlist tested at both pre (1st week) and post treatment (7th week).

Scales	Time (df = 1,50)		Condition (df= 1,50)		Treatment Condition (n= 26)		Waitlist Control Condition (n= 26)	
	F	η^2_p	F	η^2_p	Pre *M(SD)*	Post *M(SD)*	Pre *M(SD)*	Post *M(SD)*
PHQ-9	10.78*	.18	4.94*	.03	16.73(6.42)	10.85(6.62)	16.12(5.69)	17.92(4.16)
GAD-7	6.55*	.12	8.50*	.15	13.88(5.03)	9.58(5.05)	14.42(4.76)	16.08(4.04)
WS&AS	.68	.01	5.02*	.09	19.27(9.87)	15.38(9.02)	21.54(9.68)	23.12(9.39)
SWEMWBS	7.49*	.13	3.72	.07	34.77(9.72)	42.23(8.34)	33.85(11.04)	34.54(9.44)

Note: *= p <.05.

A 2x2 mixed factorial analysis of variance (ANOVA) was conducted (condition, treatment vs. waitlist control; intervention time, pre-post) on the depression (PHQ-9) scores. There was a significant main effect of condition with the treatment group reducing participants severity of the PHQ-9 symptoms more than the waitlist control group (see Table 2). There was also a significant main effect of time with the post-intervention group reducing their depressive symptoms over the seven weeks compared to at the start of the session (see Table 2). Further, there was an interaction effect between condition and time on the depression scale (PHQ-9), $F(1,50)$= 38.36, p <.001, $\eta 2p$= .43 with a medium standardised effect size. It can be seen in Figure 1 that participants who attended all

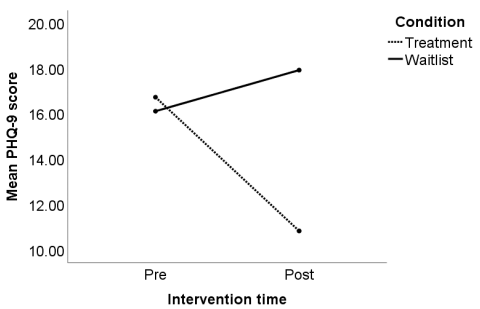

Figure 1. Mean PHQ-9 score as a function of intervention time and condition.

seven sessions of the workshop reduced their depressive symptoms over the seven weeks (post intervention) considerably, compared to the participants in the waitlist condition.

Post-hoc pairwise comparisons (with alpha levels adjusted according to Bonferroni), justified by our interaction effect, showed that participants who completed all seven CSW treatment sessions (postintervention), significantly reduced their depressive symptoms by 5.89 (raw effect size) compared to the start of the intervention (p <.001). This was compared to the waitlist group where participants' PHQ-9 scores increased by 1.81 at the end of the seven weeks compared to the beginning of the intervention period (p= .05).

Furthermore, a 2x2 mixed factorial ANOVA was conducted (condition, treatment vs. waitlist control; intervention time, pre vs. post) on the anxiety (GAD-7) scores. This analysis revealed a significant main effect of condition where participants who engaged in the CSW treatment intervention significantly reduced their anxiety symptomatology compared to participants in the waitlist control group (see Table 2). In addition, there was a significant main effect of time as participants' symptoms of anxiety significantly improved at postintervention compared to preintervention (see Table 2). These main effects were qualified by a significant interaction effect between condition and time on the GAD-7 scores, $F(1,50)$= 33.03, p <.001, $\eta 2p$= .39, with a small-to-medium standardised effect size. As seen in Figure 2, participants who attended all seven CSW sessions, significantly reduced their anxiety symptoms at postintervention, compared to the waitlist condition.

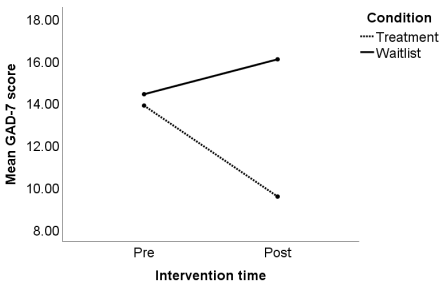

Figure 2. Mean GAD-7 score as a function of intervention time and condition.

Post-hoc pairwise comparisons (with alpha levels adjusted according to Bonferroni) revealed that there was a significant difference between the treatment and waitlist conditions with participants in the CSW treatment group demonstrating significantly decreased anxiety scores (raw effect size of 4.48) after completing the seven sessions (p <.001). In contrast, participants in the waitlist control group, showed increased anxiety scores when contacted at the seventh week compared to the first week (p= .03), with the raw effect size being negligible (1.65).

General wellbeing scale (SWEMWBS) was analysed with a 2 (Condition: treatment vs. waitlist control) x 2 (Intervention time: pre vs. post) mixed factorial ANOVA analysis. As expressed in Table 2, there was no significant main effect of condition (p= .06) on SWEMWBS scores. However, there was a significant main effect of time with participants who completed the seven sessions scoring significantly higher on general wellbeing than at the start of the session (see Table 2). Nevertheless, there was a significant interaction between condition and time on the SWEMWBS scale, $F(1,50)$= 5.16, p= .027, $\eta^2 p$= .09, with a medium standardised effect size. This interaction effect indicates that participants

in the treatment condition had improved general wellbeing scores at postintervention, compared to the waitlist condition (see Figure 3).

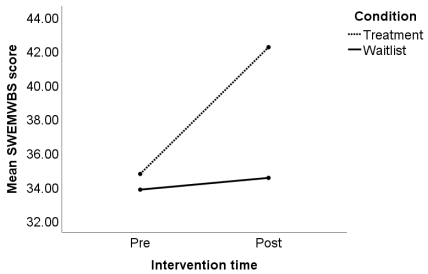

Figure 3. Mean SWEMWBS (general wellbeing scale) score as a function of intervention time and condition.

Post-hoc pairwise comparisons (with alpha levels adjusted according to Bonferroni) indicated that, as hypothesised, participants in the CSW treatment group significantly improved their general wellbeing score considerably by 7.46 at the end of seven weeks intervention (p= .001). In contrast, participants in the waitlist control group did not significantly differ in their general wellbeing scores at pre-to-post intervention (p= .74), with the raw effect size of the difference being trivial (.69).

Although there was a significant main effect of condition with the CSW treatment group participants scoring improvements on their daily functioning (WS&AS) compared to wait-list controls (see Table 2), there was no significant main effect of intervention time on the WS&AS scores. Additionally, the interaction effect between condition and time was not significant, $F(1,50)$= 3.82, p= .06, η^2p= .07, with a medium standardised effect size.

Lastly, a multiple regression was conducted using the enter method to predict general wellbeing (SWEMWBS) score from the depression (PHQ-9) and anxiety (GAD-7) scores at postintervention. These variables accounted for a large and statistically significant amount of the variance in predicting SWEMWBS score, R^2Adjusted=.42, $F(2, 49)$= 19.14, p <.001. However, only the PHQ-9 scale added to the predictive ability of the regression equation at a level which was statistically significant (see Table 3). The negative beta values indicate that reduction in participants' PHQ-9 and GAD-7 scores, both lead to improvements in general wellbeing (SWEMWBS) at postintervention.

Table 3. Individual predictor variables of depression (PHQ-9) and anxiety (GAD-7) measures on wellbeing (SWEMWBS) scale at post-score intervention (N= 52).

Variable	*B*	Standardised *B*	*t* value	*p* level
PHQ-9	-.84	-.55	-2.72	.009
GAD-7	-.21	-.12	-.61	.55

DISCUSSION

The results support the study's main hypothesis: there were significant improvements in symptoms of depression, anxiety, and general wellbeing for the CSW group participants in comparison to wait-list controls at the end of the treatment. Overall, the PHQ-9 scores reduced (by 20%), GAD-7 scores reduced (by 45%) and there was an improvement in SWEMWBS scores (17%). Therefore, the overall effectiveness of the CSW at PCMHS

in improving mental health, wellbeing and functioning is in the medium-to-high range in magnitude. However, the scores in work and social functioning (as measured by the WS&AS) did not appear to show a significant change. Possible reasons for this will be discussed below.

The current findings demonstrate that a brief, seven session, transdiagnostic group programme (that is informed by both CBT and DBT models) can be an effective community treatment intervention and have significant clinical importance for participants with a broad range of mental health difficulties. There was also a significant reduction in symptomatology associated with depression and anxiety, as well as an improvement in general wellbeing (Xia *et alia*, 2011).

There is a large body of research supporting the efficacy of CBT interventions for depression and anxiety (Proudfoot, Corr, Guest, & Dunn, 2009; Spirito *et alia*, 2011; Covin *et alia*, 2008). However, as discussed previously, its utility as a brief, group intervention when treating more complex and comorbid conditions is limited (Hofmann *et alia*, 2012), even though these disorders are frequently encountered in the primary care mental health services (Department of Health, 2011; Van Schaik *et alia*, 2004; Naylor, 2020). The CSW intervention incorporates a core set of CBT-based treatment techniques (such as psychoeducation, graded exposure and cognitive restructuring) but, crucially, also includes core DBT-based strategies (in emotional regulation and interpersonal effectiveness). Empirical research has supported the use of DBT teaching skills during psychological interventions in reducing anxiety symptoms (Arch *et alia*, 2012; Landy, Schneider, & Arch, 2015), depression (Meygoni & Ahad, 2012) and greater reduction in self-harm (Stepp *et alia*, 2008; Neacsiu, Rizvi, & Linehan, 2010). By combining CBT and DBT techniques, the CSW was able to help a broader range of people who may have not been helped by CBT alone (Neacsiu *et alia*, 2014; Ritschel, Cheavens, & Nelson, 2012; Koons *et alia*, 2001).

The current study provides strong evidence that the CSW is an efficacious brief intervention in improving symptoms of depression and anxiety and general wellbeing, for individuals with mental health difficulties in a clinical setting. There is evidence that a transdiagnostic group model can be effectively delivered in a local primary care-based setting which is consistent with previous studies (Powel *et alia*, 2013; Mead *et alia*, 2005; Erickson, Janeck, & Tallman, 2007; Newby *et alia*, 2015; Eisner *et alia*, 2017). Thus, it can be concluded that the CSW approach improves participants' quality of life and their self-esteem overall (Mishna, Kaiman, & Little, 1994).

Furthermore, due to the nature of the CSW intervention (i.e. brief, structured, time-limited, group), this can be a cost-effective way of providing treatment (McDermut, 2001) compared to any other individual psychotherapy interventions (Marziali & Munroe-Blum, 1994). Also, multiple disorders (transdiagnostic) are treated in the same psychotherapy group, servicing a wide range of service-users in need of treatment (Sadock *et alia*, 2014; Rowan & Runyan, 2005). In addition, as the CSW integrates both CBT and DBT therapies, clinicians/psychologists only need to be trained under one manual (McManus *et alia*, 2010; Wilamowska *et alia*, 2010). Therefore, this integrated transdiagnostic therapy could reduce the need for costly professional training and hospitalisation (Phanthunane, Vos, Whiteford, & Bertram, 2011; McCrone, Dhanasiri, Patel, Knapp, & Lawton-Smith, 2008; O'Shea, 2019). This, therefore, increases access to more psychological therapies (Richards *et alia*, 2016; Jerrell *et alia,* 1994) within the primary care service.

Although the present findings provide strong support for the efficacy of the CSW group programme, there are several limitations to the study. Most notably, the study

was not a randomised-controlled trial (RCT). Such an approach compares treatments by randomly assigning participants to conditions without the influence of the researcher/clinician (Essock, Drake, Frank, & McGuire, 2003). However, in this study, participants in both the active and control groups were selected by clinicians in the PCMHS according to suitability for the CSW group programme. This limits our ability to generalise the findings to a broader range of service-users who typically present to mental health services. Therefore, further studies using an RCT design are warranted to further evaluate the efficacy of the CSW approach (Hariton & Locascio, 2018).

Another substantial limitation was the lack of follow-up scores to determine if participant gains were maintained over time, since data were only collected upon completion of the programme (Lubin, Loris, Burt, & Johnson, 1998; Reinholt & Krogh, 2014; Sakiris & Berle, 2019). Therefore, we do not know if recovery rates were sustained over a longer period. Thus, longer-term follow-up is necessary after, say, 2-3 years (following Tucker *et alia*, 1987) in order to evaluate whether the improvement in symptoms seen in service-users can be maintained over time.

The study population invited to attend the workshops was diverse and heterogenous, since there was a wide range of mental health diagnoses and ethnicities in the group. However, there was some under-representation such as those with high-risk mental health needs (who were not suitable for group intervention) and those service-users who do not speak English were excluded. Future studies should seek to investigate the efficacy of the CSW treatment approach for participants from people with higher risk mental health needs and from those minority populations who avoid seeking social support, before stronger recommendations can be made. Nevertheless, this study was conducted in a working, community-based NHS mental health service/trust, reflecting a 'real-life' pragmatic approach (Zwarenstein & Treweek, 2009).

There was no significant difference in WS&AS (daily impairment functioning) scores when compared at pre-to-post intervention. This may be because there were other factors outside of the scope of the group programme -such as participants' social, housing and work situations- which influenced this variable. Prins and Colleagues (2011) found that participants who engaged in treatment with higher initial depression scores, along with unemployment and lack of social support, are more likely to have moderate or severe symptoms of depression at follow-up and thus, do not change their symptomatology (Östman & Björkman, 2015). It is now common practice to invite social workers to attend the final session of the CSW 'Maintaining Wellbeing', to help those specific issues that were not addressed, enabling individuals to lead meaningful lives (Mental Health Commission, 1998).

Future research could also include a broader range of outcome measures. For example, it may be helpful to include a specific measure for people with symptoms related to personality disorders such as measures of emotional dysregulation (e.g. Difficulties in Emotion Regulation Scale -DERS; (Gratz & Roemer, 2004; Victor & Klonsky, 2016). Additional measures that include self-esteem, self-efficacy, acceptance and interpersonal relationships, and motivation (Rayner & Vitali, 2016) may also provide further, robust information.

In summary, the current study suggests that the brief, transdiagnostic, hybrid (CBT and DBT) coping skills workshop (CSW) is an effective intervention in reducing service-users' mental health symptoms. As a result, participants who completed the intervention reported significant improvements in self-reported outcome measures of depression, anxiety, and general wellbeing scores from pre-to-post intervention, compared to a waitlist control.

To build on the findings of the current study, further investigation is required to understand whether the CSW can be generalised more broadly to different populations and to see if any gains are sustained in the long-term.

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