"STEPPING INTO A NEW WORLD OF LOW INTENSITY PSYCHOTHERAPY"

David Richards, PhD
Professor of Mental Health Services Research
University of Exeter Medical School, UK

Alan Kazdin 2010, American Psychological Society Convention

- *"If the goal* [of psychological therapies research and development] *is to reach a small number, and to exclude those in need, particularly those in minority groups, particularly those in rural areas, especially those who are elderly, especially those who are young — if that is our goal, we are doing great."*

A fact

- Some psychological treatments (mainly but not exclusively CBT) are as good as pharmacological treatments in depression and better at treating anxiety disorders

Another fact

- Only 24% of people with common mental health problems receive any treatment for their difficulties, mostly in the form of medication (20%) with only 9% receiving another form of therapy or counselling and no more than 1% receiving evidence based talking treatment of any kind.

Why does it matter?

Good reason 1

- Worldwide the economic burden of this untreated anxiety and depression to economies runs to hundreds of billions of dollars annually, (estimated to be £19 billion [€23bn] in the UK alone)

Good reason 2

- Of the total disability attributed to mental disorder
  - More than half is generated by anxiety and depression
  - Less than 5% is associated with schizophrenia

Good reason 3

- It hurts like hell to be depressed or anxious

Staring into the emptiness

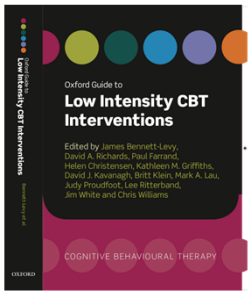
- *"During the early part of the 21st century, to be anxious or depressed was to stare across an abyss, empty of assistance."*

Richards, D.A
Br. J. Wellbeing, 2010

Access – a multi-dimensional concept

- *Availability*: an adequate supply of treatments
- *Utilisation:* the treatments people actually receive
- *Effectiveness*: improvements in health status, function and quality of life
- *Cost-effectiveness:* improvements achieved at a sustainable cost
- *Equity*: treatments delivered to the population according to need; unrestricted by the ability to pay, geographic location, culture or other moderator
- *Patient-centredness*: services provided in line with people's expressed preferences and needs

Low Intensity Psychotherapy: Dawning of a New Paradigm?



Low Intensity Psychotherapy

= a **values-driven approach** to mental health, based on principles of social justice and equity, which seeks to *democratise access to effective evidence-based psychological interventions*

Jane

- 43, Single parent (separated year ago)
- Clinical depression (moderate range)
- Part-time community worker
- Behind with mortgage
- Lives rural community 20 miles from town

Traditional option

- 4-12 month waiting list
- Therapy approx. cost €1500
- Knows Dr. Jones the therapist
- Only available in office hours – time off work/childcare
- 40 mile round trip to town
- Therapist not integrated with community services

Psychotherapy

- Essentially same model since 1890s
- One to one
- Come to my clinic
- 50-60 mins weekly
- In office hours
- Pay (usually) - or huge waiting list

Problem

The current system is:

- Ineffective
- Inefficient
- Discriminatory

AND

- Does everyone want 1 to 1 therapy?
- Do some prefer to learn through other means?

Low Intensity Psychological Interventions: A revolution in Mental Health care?

Purpose: **To increase access** to evidence-based psychological therapies by:

1. Min level of intervention for max therapeutic gain
2. Minimising specialist therapist time
3. Maximising patient choice: deliver therapy in variety of flexible forms (email, phone, face to face, sms, internet, books etc).
4. Often self-paced, bite-size
5. Practitioner role: coaching/support

New Ways of Working

- Guided self-help – books, internet
- Unguided self-help
- Groups (12 to 120)
- Advice clinics
- Working through other ‘low intensity’ agents

New Times/Places for Therapy (to meet consumer/patient needs)

- Home
- Libraries
- Evening classes in community
- One-off consultations (advice clinics)
- Email
- Internet chat rooms/bulletin boards

New Communication Tools

- Email
- Phone
- Internet
- SMS
- Bulletin Boards
- Chatrooms
- Palm-top computers/tablets
- Virtual reality

New Systems Models: Client-centred

- Stepped Care
- Collaborative Care
- Routine Monitoring and Outcomes Data

New Workforce

- Clinical techniques are 'in the materials'
- Different skills
- Don't need specialists?

New Orientation to Consumers

- 'Greeters not Bouncers'
- Self-help/Empowerment
- Consumer choice – of materials, of type of service delivery

Low-intensity Psychotherapy

Does it work?

Systematic Review

- *"Method. We conducted a meta-analysis of randomized controlled trials in which the effects of guided* **[!]** *self-help on depression and anxiety were compared directly with face-to-face psychotherapies for depression and anxiety disorders. A systematic search in bibliographical databases (PubMed, PsycINFO, EMBASE, Cochrane) resulted in 21 studies with 810 participants.*
- *Results. The overall effect size indicating the difference between guided self-help and face-to-face psychotherapy at post-test was d=-0.02 (95% CI -0.20 to 0.15) in favour of guided self-help* **[i.e. no difference]**. *At follow-up (up to 1 year) no significant difference was found either. No significant difference was found between the drop-out rates in the two treatments formats."*

Cuijpers et al, Psychological Medicine (2010), 40, 1943–1957

Jane

Traditional 1-to-1 System	Low Intensity Service
4 month waiting list	Service within 3 weeks
$1000	No payment
Knows Dr. Jones	Not know Low Intensity worker
Only available in office hours – time off work/childcare	She can do program anytime - can work, not need childcare
40 mile round trip	No transport necessary
	Choice of materials –IT/book
Therapist not linked to community services	Direct linkage to financial counsellor through LI Service

But things are never that simple……

- Implementing Low Intensity Therapy

The current paradox

- We have treatments
- We appear unable to deliver them; e.g.
  - only about 40% - 50% of depressed primary care patients who are referred to a mental health specialist in the community actually make an initial visit
  - the median number of visits among those who follow through with referral in most large mental health clinics is approximately two
  - many patients who do reach mental health professionals do not receive evidence-based psychotherapy

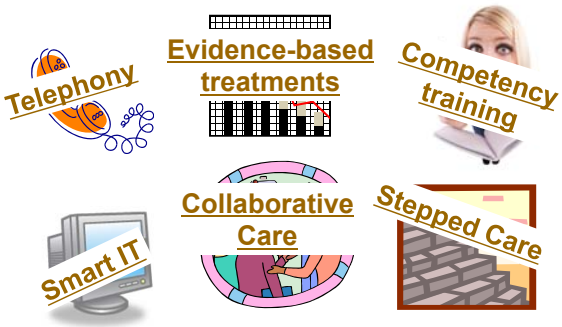
Treating high-prevalence mental health problems – the UK Improving Access to Psychological Therapies Programme 2008-2015

- Investing £700m (€853) wisely?

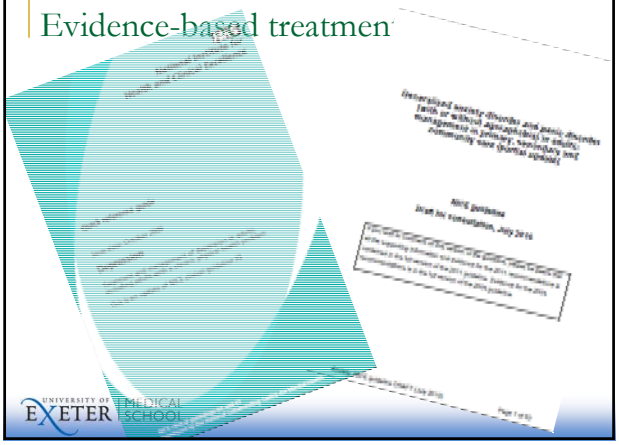
IAPT

- A programme to **implement** NICE approved **evidence-based** psychological treatments in the UK
- New high-volume clinical services for depression & anxiety disorders set up nationally
- Includes a major training programme to train 6000 new mental health workers competent to deliver evidence-based psychological therapies
- Stepped care used to organise treatment at 'low-intensity' and 'high-intensity'
- Therefore a new para-professional group created for low-intensity delivery

IAPT Architecture

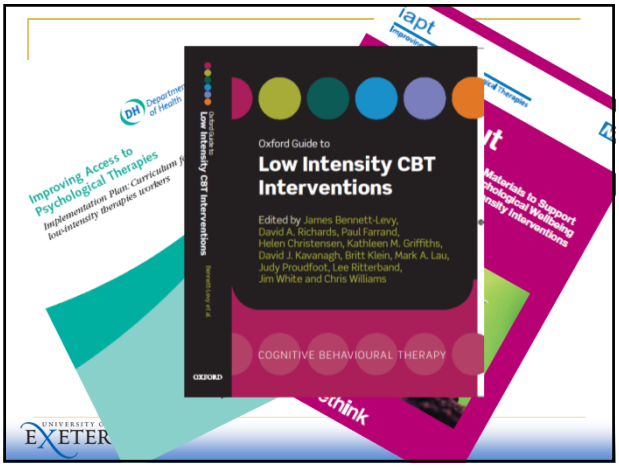


Evidence-based treatmen



Competency Training

- Two new courses, ratio low 2:3 high
- National curricula
- Competency based
- Multi-professional (e.g. around 33% of high-intensity trainees are nurses)



Education and Training of Psychological Wellbeing Practitioners

- Two principles for skills training:
  - Clinical simulation at HEI
  - Supervised practice in workplace
- Two types of course
- 4 modules (2 for professionally qualified staff)
- 45/25 days education and training
  - 25/15 in HEI, 20/10 in workplace
- Essential common and intervention specific competencies

Smart IT for Clinical Case Management

- Clinical data should be collected **at every session** in real time
- Clinical and process data should automatically trigger supervision alerts
- Supervisors and supervisees should be able to view the same electronic data
- The Electronic Health Record (EHR) should summarise and present data in a format to aid clinical decision making, not just to collect audit data

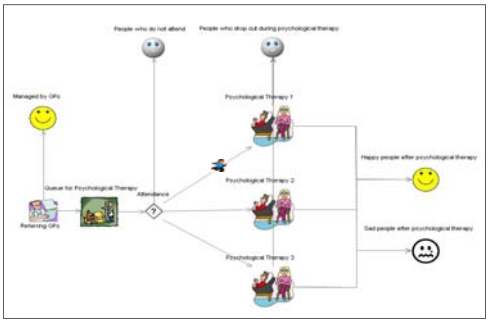
Stepped Care

- Stepped care was developed as a modification of the *psychological referral* model to maintain effectiveness and patient-centredness benefits by providing personally tailored evidence based treatment
- minimising access and efficiency problems by delivering treatment in a 'low-burdensome' manner to a proportion of patients.

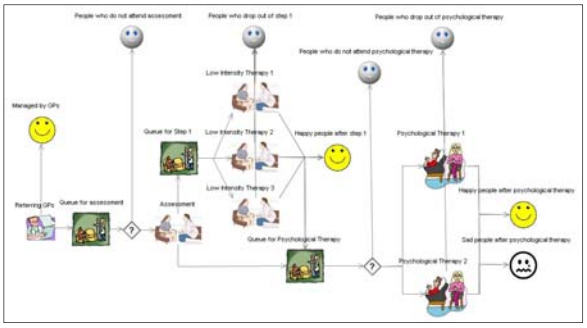
Stepped Care

- Two principles
  - 'least burden'.
  - 'self-correction'
- treatment received by a patient should always be the least restrictive, delivering good outcomes whilst burdening the patient and the health care system as little as possible
- a system must be in place to detect non-improvement leading to alternative more intensive treatments being offered

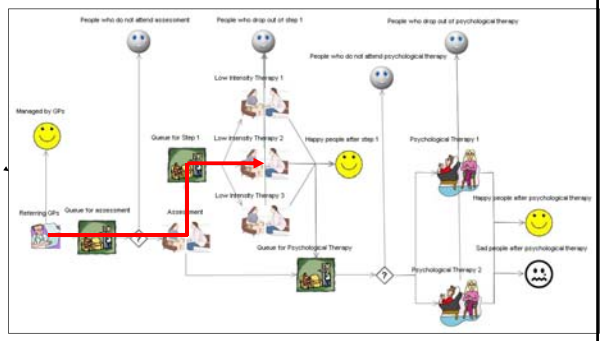
First – the old picture



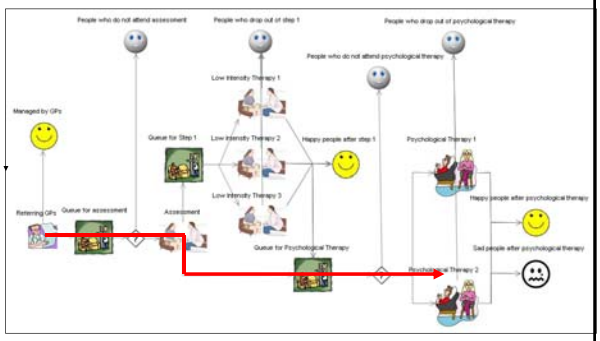
A New Picture



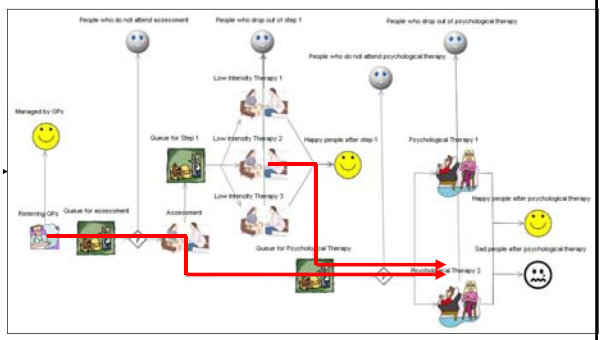
Stepped Care: Low-Intensity Path



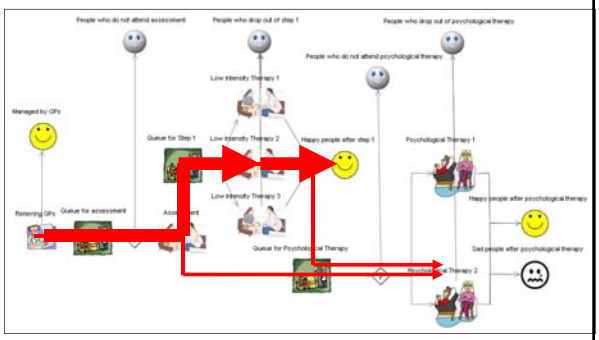
Stepped Care: High-Intensity Path 1



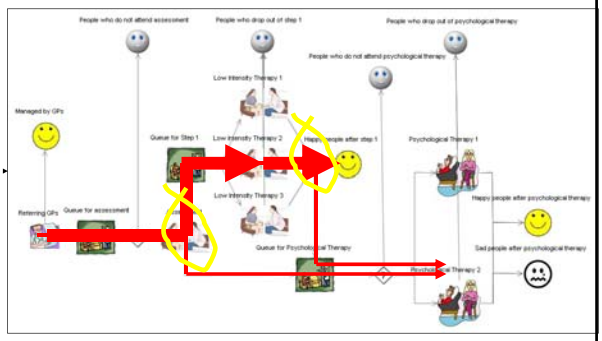
Stepped Care: High-Intensity Path 2



Stepped Care: Ideal Balance



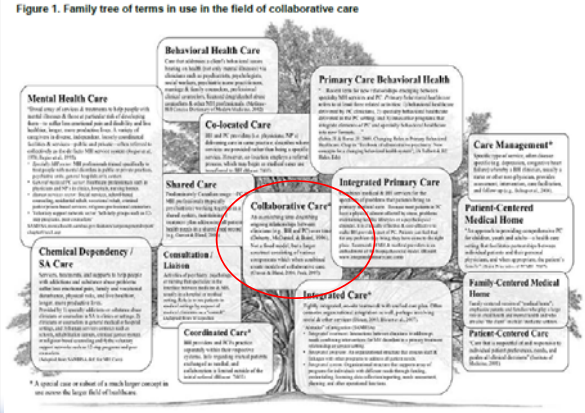
Stepped Care: Decision Points



Collaborative Care

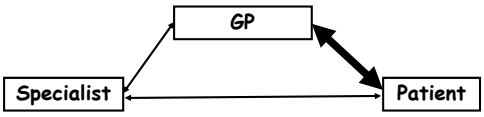
- Collaborative care was developed to increase access, equity, efficiency and effectiveness
- Evolved by employing case managers to work directly with patients and support general practitioners in delivering care

Figure 1. Family tree of terms in use in the field of collaborative care

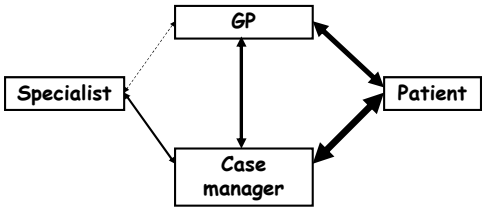


US Agency for Healthcare Research and Quality (AHRQ) 2011

Usual care relationships

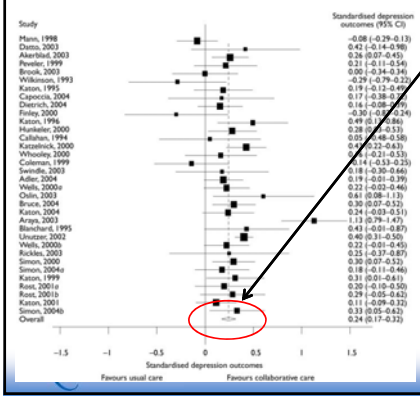


Collaborative care relationships



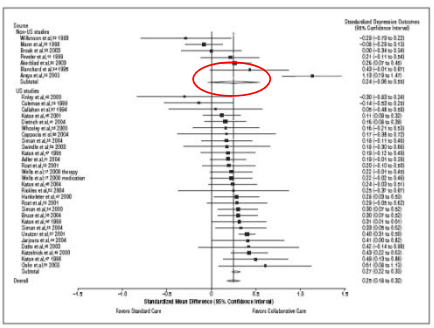
Collaborative Care

ES = 0.24 (95% CI 0.17 to 0.32)



Bower et al. *BrJPsychiat.* 2006

The International Literature



CADET: Clinical & Cost Effectiveness of Collaborative Care for Depression in UK Primary Care: A Cluster Randomized Controlled Trial

David Richards, PhD

"This presentation reports independent research funded by the MRC and managed by the NIHR on behalf of the MRC-NIHR partnership. The views expressed in this presentation are those of the author(s) and not necessarily those of the MRC, NHS, NIHR or the Department of Health."

Research Question

- Is collaborative care more clinically and cost effective than usual care in the management of patients with moderate to severe depression in UK primary care?
- Design: Cluster RCT
  - 3 sites – Manchester, London, Bristol


BMJ

RESEARCH

Clinical effectiveness of collaborative care for depression in UK primary care (CADET): cluster randomised controlled trial

Richards DA et al. CADET: Clinical Effectiveness of Collaborative Care for Depression in UK Primary Care. A Cluster Randomised Controlled Trial. *British Medical Journal* , 2013;347:f4913

Collaborative Care Intervention

- Usual care from their GP plus:
  - 6-12 case manager contacts with participants over 14 weeks
  - 30-40 minutes for an initial face to face appointment followed by 15-20 minute telephone contacts thereafter
- Contacts included:
  - education about depression; medication management; behavioural activation; and relapse prevention advice
- Communication with primary care
  - case managers provided GPs with regular updates and patient management advice at least four weekly and more often if clinically indicated

Case Managers

- Para-professional primary care mental health workers with post-graduate education in mental health care
- Additionally trained for five days in collaborative care
- Received weekly supervision
  - from specialist mental health professionals including clinical psychologists, psychiatrists, academic general practitioners with special interest in mental health or a senior nurse psychotherapist

Outcome Measures

Primary Outcome
Depression at 4 months, PHQ-9

Secondary Outcome
Depression at 12 months, PHQ-9

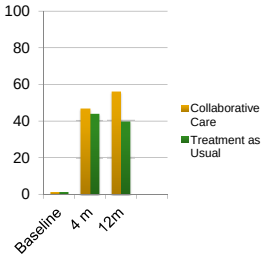
Other Secondary Outcomes at 4 & 12m

Anxiety	GAD7
Quality of Life	SF36
Health Care Utilisation	Questionnaire
Health State Utilities	EQ5D
Satisfaction with Care	CSQ-8
Process of implementation	Clinical records

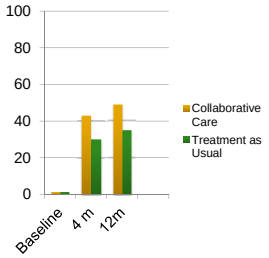
Sample size: 581
Follow up 4m: 505 (87%)
Follow up 12m: 498 (86%)

Clinical Recovery and Response Rates

Recovery rates: % PHQ-9 ≤ 9 at follow up

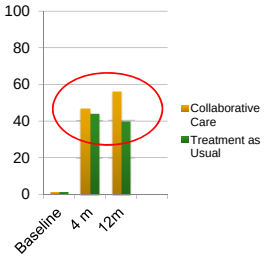


Response rates: ≥ 50% PHQ-9 reduction from baseline

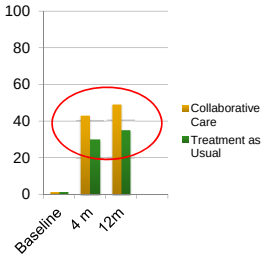


Clinical Recovery and Response Rates

Recovery rates: % PHQ-9 ≤ 9 at follow up



Response rates: ≥ 50% PHQ-9 reduction from baseline



Secondary Outcomes

- Collaborative care:
  - produced better outcomes than treatment as usual on the mental component scale of the SF-36 at four but not 12 months,
  - had little additional effect on anxiety and the physical component scale of the SF-36 compared to treatment as usual
  - participants receiving collaborative care were more satisfied with their treatment than those receiving treatment as usual

Summary

- We found that collaborative care in the UK
  - has persistent positive effects,
  - is cost effective against commonly applied decision-maker willingness to pay thresholds
  - patients are more satisfied compared to treatment as usual
- Exactly in line with international literature

Cochrane (2012) meta-analysis of 79 RCTs

- Overall SMD = 0.29 (95% CI 0.25 to 0.33)
- CADET SMD = 0·26 (0·07 to 0·46) no different from:
  - US SMD = 0·29 (0.24 to 0.33)
  - non-US ex-the UK SMD = 0.33 (0.23 to 0.43)
  - UK SMD = 0·25 (0·13 to 0·37)
- Collaborative care in the UK is as effective as US trials, therefore, for an example of a taxation-funded, integrated health system with a well-developed primary care sector

What about IAPT research?


Improving access to psychological therapy: The Doncaster demonstration site organisational model

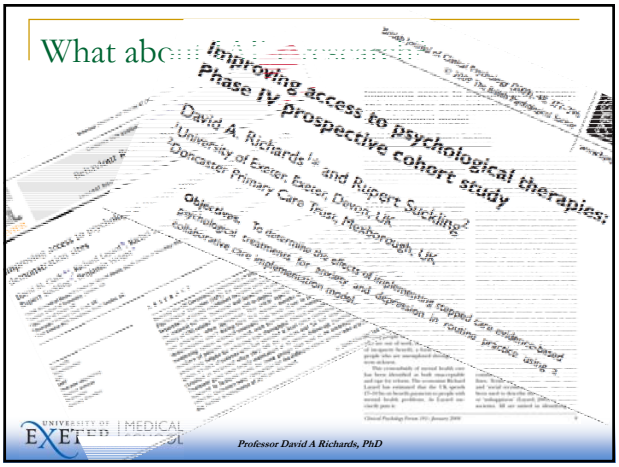
David A. Richards & Rupert Suckling

What about IAPT research?


Improving access to psychological therapy: The Doncaster demonstration site organisational model

David A. Richards & Rupert Suckling

What abo


Improving access to psychological therapies: Phase IV prospective cohort study

David A Richards[1,2] and Rupert Suckling[2]

[1]University of Exeter, Exeter, Devon, UK; [2]Doncaster Primary Care Trust, Mexborough, UK

Objectives: To determine the effects of implementing stepped care evidence-based psychological treatments for anxiety and depression in routine practice using a collaborative care implementation model.

What abo

Journal of Affective Disorders 133 (2011) 51–60

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research report

Implementation of psychological therapies for anxiety and depression in routine practice: Two year prospective cohort study

David A. Richards [a,*], Gunilla Borglin [b]

[a] Mood Disorders Centre, College of Life and Environmental Science, University of Exeter, Exeter EX4 4QG, United Kingdom
[b] School of Health Science, Blekinge Institute of Technology, SE-379 71 Karlskrona, Blekinge, Sweden

ARTICLE INFO

Article history:
Received 6 December 2010
Received in revised form 9 March 2011
Accepted 9 March 2011
Available online 17 April 2011

ABSTRACT

Introduction: Worldwide, health systems are improving access to empirically supported psychological therapies for anxiety and depression. Evaluations of this effort are limited by the cross sectional nature of studies, short implementation periods, poor data completeness rates and lack of clinically significant and reliable change metrics.
Objective: Assess the impact of implementing stepped care empirically supported psychological

The first three years: latest data

- Key successes of the programme in the first three full financial years from 2008-2011 include:
  - Over 1 million people entering treatment
  - 680,000 people completing treatment
  - Recovery rates consistently in excess of 45%
  - 65% of people significantly improved
  - Over 45,000 people moving off sick pay and benefits
  - Nearly 4,000 new clinical practitioners trained

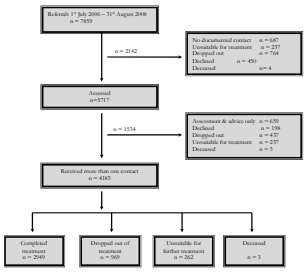
Two year prospective cohort

- Evaluations of implementation programmes worldwide, including IAPT, are limited by the cross-sectional nature of studies, short implementation periods, poor data completeness rates and lack of clinically significant and reliable change metrics
- Therefore, we collected demographic, therapeutic and outcome data on depression (PHQ-9) and anxiety (GAD-7) from 7,859 consecutive patients for 24 months between1st July 2006 and 31st August 2008, following up these patients for a further one year to determine their final disposition
- In contrast to previous cross-sectional IAPT studies, ALL patients had completed their involvement with the service by the census date

Headline outcome results

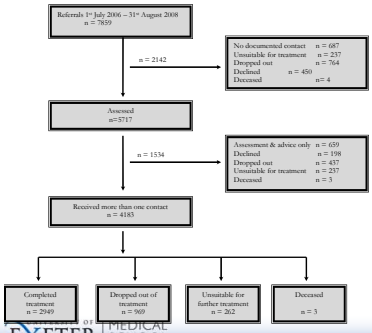
- 53% of referrals received two or more treatment sessions.
- Uncontrolled effect size for depression was 1.07 (95% CI: 0.88 to 1.29) and for anxiety was 1.04 (0.88 to 1.23) in all patients receiving 2 or more sessions (including dropouts)
- 55.4% of treated patients met reliable improvement or reliable and clinically significant change criteria for depression, 54.7% for anxiety
- Patients received a mean of 5.5 sessions over 3.5 hours, mainly low-intensity CBT and phone based case management
- Attrition was high with 47% of referrals either not attending for an assessment or receiving an assessment only

Patient flows through service



- 61% of assessed and suitable patients complete treatment
- Effect size of treatment completers: 1.21-1.24 with reliable plus reliable and clinically significant change rates: 61%
- Effect size for any patient receiving treatment (inc D/Os): 1.04-1.07; reliable plus reliable and clinically significant change rates: 54.7-55.4%
- But: 27% of patients lost at each stage

Where do all the Patients Go?



-27%

-27%

-27%

Engagement and attrition

- Despite waiting a full year after patients had been referred to, and logged by, the service, only 4183/7859 (53%) of referred patients received two or more sessions of assessment and then treatment
- Whilst some patients may have been satisfied with a single advice session, many more were lost to the service before and after assessment
- We are still relatively poor at engaging and retaining our patients in routine practice
- Further work is needed to understand and improve engagement and utilisation for patients with anxiety and depression in routine services

Access – a reminder

- *Availability*: an adequate supply of treatments
- *Utilisation:* the treatments people actually receive
- *Effectiveness*: improvements in health status, function and quality of life
- *Cost-effectiveness:* improvements achieved at a sustainable cost
- *Equity*: treatments delivered to the population according to need; unrestricted by the ability to pay, geographic location, culture or other moderator
- *Patient-centredness*: services provided in line with people's expressed preferences and needs

Access Conclusions

- We will not comprehensively improve access with:
  - The existing workforce
  - Existing treatments
  - Existing systems
  - Existing guidelines
  - Using a fee for service system
    - Taxation and State insurance systems work (partially)

Implementation and Access

- Put in place systems to ensure treatment fidelity and worker competence
- Reduce patient attrition
  - Currently 25-40% of patients assessed and found suitable for treatment drop out
- Ensure high levels of data collection
- Work for equity
- Think harder about acceptability

Conclusion

- "*Depression and anxiety are not an unfortunate and inevitable sequelae of life's ups and downs.*
- *Exclusion from social participation, work and meaningful relationships are not unavoidable.*
- *In England, if you are distressed, struggling or facing an uncertain future you are no longer told you are 'unsuitable' for assistance.*
- *IAPT has changed the landscape of mental healthcare in England*"

Br. J. Wellbeing, 2010

"*IAPT has changed the landscape of mental healthcare in England*"

- …or has it…
- A final (utopian) vision seen in local UK shop…


FUNKY CUT & FINISH £26*
SHOULDER TO CRY ON FREE
SCAN THROUGH THE MAGS FREE

Thank you.